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ADMINISTRATION'S FISCAL YEAR 1984 BUDGET PROPOSALS—II

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

JUNE 15, 16, 22, 23, 28, AND 29, 1983

PART 2 OF 4

JUNE 22, 1983 FRINGE BENEFITS

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ADMINISTRATION'S FISCAL YEAR 1984 BUDGET PROPOSALS—II

WEDNESDAY, JUNE 22, 1983

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:02 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Robert Dole (chairman) presiding.

Present: Senators Dole, Packwood, Chafee, Durenberger, Wallop, Long, Bentsen, and Bradley.

The press release announcing the hearing, the opening statements of Senators Durenberger, Heinz, and Mitchell and the explanation of S. 640 by the Joint Committee on Taxation follows:

FINANCE COMMITTEE ANNOUNCES HEARINGS ON FISCAL YEAR 1984 BUDGET PROPOSALS

Senator Robert J. Dole (R., Kans.), Chairman of the Senate Committee on Finance, today announced hearings for June 15, 16, 22, 23, 28, and 29, 1983, on budget proposals for programs within the jurisdiction of the committee.

"The Williamsburg Summit Conference produced a clear message that Congress must act to reduce the projected Federal budget deficits to avoid jeopardizing the global economic recovery." Senator Dole stated, "In my view, the only 1984 budget blueprint that is likely to result in actual reduction of the deficit will be one that places the primary emphasis on spending reductions rather than on tax increases."

"Any new revenue—if needed—should come from tax reform not tax increases. The hearings I am announcing today should assist the Finance Committee in preparing to implement any balanced and responsible budget compromise that may emerge," Senator Dole concluded.

The hearings will begin on each day noted at 10:00 a.m. in Room SD-215 of the Dirksen Senate Office Building.

The following is a schedule of hearings:

TAX HEARINGS

Fringe benefits

On June 22nd the committee will hold a hearing on the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income. At that time, the committee will also review the public policy and tax compliance implications of the present law tax treatment of other statutory and nonstatutory fringe benefits and the effect of the moratorium on fringe benefits regulations which is scheduled to expire on December 31, 1983.

OPENING STATEMENT BY SENATOR DAVE DURENBERGER ON THE TAX CAP

The hearing today on the Taxation of Fringe Benefits is only the first in a series that will be held this week and next. Tomorrow the Finance Committee will examine tax compliance issues and next week we will take a broader look at tax expenditures.

One purpose of these hearings is to examine options for creating better tax policy. Over the past fifty years the federal tax base has narrowed considerably. As a result, tax rates have been forced to remain quite high. The tax base is rapidly eroding to the point where the federal government actually loses more through tax expenditures than it collects through income taxes. The corrections in tax policy we started last year clearly need to be continued.

But there's another purpose to these hearings. In many cases, tax policy has a direct impact on other public policies—like Health Policy, Education Policy, or Intergovernmental Policy. Changes in tax policy can have broad ramifications, and we must carefully gauge their impact.

Fringe Benefits provide a case in point. From a tax policy standpoint, fringe benefits are nothing but a big loophole. The estimated revenue loss in 1983 from untaxed fringe benefits is over $35 billion. But fringe benefits like Health or Education can help meet a valuable societal goal. And in many cases, employers can do a better job of providing services and meeting these goals than can the federal government.

We are only now concluding a bitter and divisive debate over withholding. Emotions on the issue have run high. But we must not let our emotions obscure the valuable lessons learned from the debate. Those lessons have direct applications to our discussions on fringe benefit taxation, tax compliance, and tax expenditures.

Mark Olson, President of the Security State Bank in Fergus Falls, Minnesota, summarized those lessons well in an article in the ABA Banking Journal. Mr. Olson points out that the withholding issue has been, from the very beginning, a people issue. He describes roots far deeper than the law itself.

First, he cites the public's failing confidence in government. Government has become too insensitive and too unresponsive to individuals. The public has lost trust in its government. But the people still believe that government can be made to work.

Second, the majority of Americans who pay taxes don't like to be treated like cheats. Tax policy should be designed to target the abusers, not the entire population of taxpayers.

Third, the American public feels that income taxes are too high. This sentiment is not so much that the absolute level of income taxes is too high. Compared to income tax rates in Western Europe, America may look pretty good. But that's not the way Americans judge their relative standing. Americans look at the guy next door, and compared to Mr. Jones and all his tax shelters, the average American figures he is paying too much.

Finally, Mr. Olson points out that the American dream of getting ahead has been replaced by a struggle to stay even. Americans feel they have lost control over their lives, their jobs, and their future.

Given these lessons, it's easy to see why the issues of fringe benefit taxation, tax compliance, and tax expenditures are likely to touch a raw nerve among taxpayers. It's not that Americans want fringe benefits to go untouched and untaxed. No, the lesson is that Americans want fringe benefits to be treated equitably.

Take the issue of Health Benefits. I don't think anyone would question that employer-provided health benefits have significantly improved access to quality medical care in this country. Employers began providing health insurance as a fringe benefit in 1943. This year, however, employers will provide for over $100 billion in health insurance premiums to cover 68 million employees and their families.

By any measure, employer-provided health insurance has been a remarkable success. Employers who started 30 years ago by offering simple hospital coverage now pay for physicians, drugs, dental care, and a host of other services. Expanded benefits make everyone happy. Employees are better protected, providers are assured of payment, and employers are furnishing a valuable service.

Employers have also done a good job of administering health benefit plans. Employers are at the forefront in offering multiple-choice of plans, ambulatory surgery coverage, peer review, and pre-admission certification.

But I don't believe Congress or the American public ever intended the tax subsidy for employer-provided benefits to grow into our second largest federal health care program. Only medicare, with 1983 expenditures of $57 billion, is more expansive than the $29 billion lost on the tax subsidy.

As a former employer, I'm very familiar with the employer mind-set. We were anxious to expand health benefit coverage for our employees. The broader the benefits, the better we were serving our employees. It seemed like we couldn't broaden benefits fast enough. But what we thought was a blessing turned out to be a curse. We had shackled ourselves, our employees, and our medical system with a set of golden handcuffs.

We're only just beginning to recognize how hard it is to take those golden handcuffs off. Most employees are scared to. They're afraid of catastrophic health expenses. And they have been led to believe that medical care costs are out of their control. As patients they believe the medical system makes decisions for them. As medical care consumers they feel impotent.

Furthermore, a dollar in the form of health benefits is an untaxed dollar. Better for employees to receive that dollar in the form of health insurance than in the form of taxable wages.

Medical care providers are not inclined to loose those handcuffs either. After all, health insurance is like having a blank check to do just about anything they want. No one has to worry about cost.

Employers are just beginning to realize that they are the ones hurt most by the golden handcuffs. As medical costs go up, it's employers feeling the pinch. By being so anxious to broaden coverage for its employees, employers are now getting clobbered by rising medical care costs.

Former Health and Human Services Secretary Joe Califanc recently spoke to the Economic Club of Detroit on the problems in our health care system. He said that 94 percent of all hospital bills are paid for by medicare, medicaid, or private insurers. That system, he said: "Is like having a credit card to use at restaurants—and never getting a bill. We would all order caviar, lobster, steak and Dom Perignon and that's the only food and champagne the restaurant would stock. (The Restaurant owner) * * * would have no concern about moving out the first sitting and turning the tables over twice each evening * * * The third party, fee for service, cost plus health care reimbursement system provides only the illusion of a free lunch. In reality, we are all paying for this meal—and in ten short years, the bill will hit at least $1 trillion—unless we do something about it."

Chrysler, the company for which Joe Califono consults, is feeling the full bite of the golden handcuffs. Health insurance premiums are costing the Chrysler Corporation over $300 a month for family coverage. Yet Chrysler cannot break the grip. Even when Chrysler was flat on its back and struggling for its very survival, the company was compelled by its employees to drop its coinsurance from 20 percent to 10 percent. Employers are now beginning to recognize the value of patient cost sharing. They're beginning to recognize that employees can help keep medical costs down, if they have a reason to. Consequently, more and more employers are trying to introduce coinsurance and deductibles in their health benefits plans.

A new survey by Towers, Perrin, Forster & Crosby shows that employers rated coinsurance and deductibles very high as cost-containers, 3.8 on a scale of 4. Yet, at the same time, a Hay Group study showed that only 13 percent of 800 major companies raised deductibles last year. Employers seem to know what they want to do, but they can't get there. The golden handcuffs have them trapped.

I mentioned earlier that one of the lessons of withholding is that Americans are tired of loopholes. As long as we leave the golden handcuffs untouched, we are leaving in place a massive and terribly unfair tax loophole. Unless we do something to limit that loophole, public sentiment will mount to do away with it altogether. In fact, advocates of a flat rate tax have proposed getting rid of the tax subsidy for health benefits altogether.

That's going too far. I, and I think most Americans, believe that the health of America depends on wise investment in insurance against accident, illness, and catastrophe. Employer-based health coverage is a good way to achieve that goal. And the best way to preserve the special role of the employer is to place a reasonable limit on the tax subsidy. That way, the employer and employee can work together to bring price sensitivity and need to the health care purchase.

An unlimited tax subsidy for employer-provided health benefits is bad health policy, but it doesn't stop there. It's also lousy tax policy.

Suppose a member of Congress proposed a tax loophole of $29 billion a year of which less than 4 percent of the benefits went to the poorest 29 percent of our population—those households earning $15,000 or less—and 35 percent of the benefits went to the 18 percent of households earning $50,000 or more.

The outrage of most American families over such a proposal would be loud and justified. Yet that is exactly the kind of loophole provided by our present open-ended subsidy. The average national cost of employer-paid health insurance for family coverage is $120 a month. Think about it. The average is $120 a month. Auto workers are receiving over $300 a month in health care benefits—more than two and a half times the national average. The difference in employer payments between the average family plan and the auto workers plan is $2,184 per year.

Who pays that $2,184? Is it General Motors? Chrysler? Ford? No! It's you and I getting stuck with the bill. We're paying for it because our taxes have to be raised to cover the revenue loss generated by those rich benefits. It's the American taxpayer who pays the price. Taxpayers fork out thiry cents for every dollar spent on employer-based health insurance.

The inquity of this subsidy is not going unnoticed. I get letters every week from irate farmers and independent businessmen who do not get the break for health insurance that employees of large companies get. They aren't asking for a tax subsidy. They're simply asking for equal treatment. They want everyone to be treated the same way.

I think we have to go back and ask ourselves why we provide a federal subsidy for the purchase of health insurance. Certainly we want to encourage Americans to protect themselves against the cost of catastrophic illness. We do not want our citizens knocked out by the high cost of illness.

But I do not believe a federal subsidy is necessary or appropriate for the relatively routine expenses that can be budgeted for. Individuals should be given some responsibility to take care of themselves. We should not need a subsidy to prod us into doing those things that are good for our health—things like keeping our weight down, our teeth clean, and our bodies fit.

Furthermore, if we permit individuals to use tax-free dollars to protect themselves against hospital, physician, dental, eyeglass, and prescription drugs, why not also extend the subsidy for jogging clothes, exercycles, stress management classes, the purchase of low cholesterol foods, and health club memberships? Where do we draw the line? It seems to me that at some point we have to rely on the individual to make his or her own decisions about cost, value, and need.

Some people feel the federal government should qualify employer-based health plans. The federal government could set deductible amounts, coinsurance rates, covered services, and catastrphic limits. Cost-sharing is a good idea. But who will decide how to do it? I don't think anyone around here knows how to shape it. Any steps we take to try and define a cost-effective plan assume we know the best arragements. We don't.

In some cases, deductible and coinsurance may be a good idea. But those decisions should be made by employees, employers, insurance companies, and health providers. What makes sense in one situation may not make sense in another. A coinsurance requirement for hospitals could severely impede the development of Health Maintenance Organizations. HMOs could be given some kind of exemption.

But what about Preferred Provider Organizations? In these plans, reduced cost sharing is used as an incentive to attract consumers to more efficient physicians. Would we write another exemption for these kinds of plans? And who knows what other kinds of new organizations we might preempt by legislating plan requirements? It seems to me that the most appropriate thing the federal government can do is to create the conditions for price sensitivity by imposing a cap and allow employers, employees, and health providers to structure appropriate benefit plans.

If employees, in conjunction with employers and health providers, opt to keep premiums down through additional deductables and coinsurance, that's fine. If they opt for provention, that's fine too. And if they opt for an HMO or a PPO, all the better. We need that kind of multidimensional approach to enhance innovation and keep health care costs down.

American citizens want a fair and equitable tax system. They want a private health system, and they want a hand in shaping it. A tax cap on health benefits helps achieve all of these goals, and should be supported.

OPENING STATEMENT BY SENATOR JOHN HEINZ

Mr. Chairman, as a member of this Committee's health Subcommittee, I'm pleased that this hearing has been convened to receive more information on the administration's proposal to cap the income tax exclusion for employer-provided health insurance. The issue of taxing health insurance premiums bears careful consideration by this committee, whether the proposal is viewed purely as a revenue-generating mechanism, as a way to control health care costs, or as a means to explore alternative proposals. Moreover, I strongly favor the idea of looking at our overall public policy position on the tax treatment of other statutory and nonstatutory fringe benefits.

For years we've been whittling away at the tax treatment of fringe benefits, while neglecting to make some hard decisions about which employee benefits should be tax-favored. Without question, we need to understand and weigh the social and economic benefits of all major employee fringe benefits before we make substantive changes in our tax policy. Most debate in recent years has been done in a piecemeal fashion, focusing on only one type of benefit at a time. The Congress has too long ignored looking at the broader issue of the diffiering types of tax treatment for all employee benefits.

Employers and employees, in both the public and private sectors, have placed a high value on employee benefits. The federal government has encouraged the growth of certain benefits through tax incentives. Clearly, the growth in employer benefits over the past three decades has made significant social advances for American workers.

Pensions and profit-sharing plans defer income and encourage private saving for retirement. Health benefits, disability income plans, and life insurance protection has helped shield employees and their families from the adverse consequences of unanticipated, catastrophic events. The expansion of employer pension and welfare plans has achieved major improvements in the income security of current workers and future retirees.

We do not want to reduce, erode or eliminate any of the tax incentives for employee benefits which have helped better protect workers from catastrophic events. However, the concern has been raised that the growth of benefits occurs at the expense of growth in wage and salary income. In addition, the continued erosion of the tax base affects the public sector's ability to finance government programs, especially the social security system.

We're here today for the purpose of collecting more information on the tax treatment of all fringe benefits, including employer-paid health insurance premiums. I'm concerned about a number of issues which have been raised regarding the administration's proposal to tax employee health benefits which exceed a specified premium ceiling. I hope our witnesses here today will discuss some of the potential ramifications of this proposal, such as: Would the tax cap lead to cutbacks in health insurance for workers; would the cap thwart the growth of health maintenance organizations; would the cap discourage innovative, and cost-effective coverages in some health benefit packages, such as wellness programs, vision care, dental benefits, or alcoholism programs; how would the cap be administered for self-insured companies which do not have monthly premiums; and how could the cap be revised to prevent discrimination against the workers in those regions of the country, and within a given state where health care costs are very high, and there are major regional variances in the cost of group health insurance?

I hope we can begin to answer these and other questions after we've heard the testimony from today's witnesses.

OVERVIEW OF ADMINISTRATION PROPOSAL TO CAP EXCLUSION FOR EMPLOYER-PROVIDED MEDICAL CARE (S. 640) AND OF TAX TREATMENT OF OTHER FRINGE BENEFITS

Scheduled for a Hearing

before the

COMMITTEE ON FINANCE
UNITED STATES SENATE

on

JUNE 22, 1983

INTRODUCTION

The Senate Committee on Finance has scheduled a public hearing on June 22, 1983, on the Federal tax treatment of fringe benefits. In its press release announcing the hearing, the committee stated that the hearing would include (1) the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income and (2) the public policy and tax compliance implications of the present law tax treatment of other statutory and nonstatutory fringe benefits and the effect of the moratorium on fringe benefit regulations which is scheduled to expire on December 31, 1983.

The first part of the pamphlet is a summary. This is followed by a more detailed overview of Federal tax treatment of certain statutory and nonstatutory fringe benefits, including the Administration's proposal to cap the exclusion for employer-provided medical care (S. 640). The final part sets forth background information, including revenue implications of the tax treatment of certain statutory fringe benefits, and a brief statement of some of the principal tax issues relating to fringe benefits. This pamphlet does not describe the statutory exclusion for employer contributions to qualified pension, profit-sharing or stock bonus plans, qualified annuity plans, or tax-sheltered annuity plans, or any other income tax items which may be considered fringe benefits.

I. SUMMARY

Administration proposal to cap exclusion for employer-provided medical care (S. 640)

In general, amounts paid by an employer to a health plan for the benefit of an employee are not includible in the employee's income for income tax purposes or in wages for employment tax purposes.

Under S. 640, gross income of an employee would include amounts paid by the employer to a health plan for the employee to the extent the amounts paid exceed specified dollar amounts. These threshold limits would be $175 per month for family coverage and $70 per month for individual coverage. In addition, the amount includible as income would also be subject to social security, railroad retirement, and unemployment payroll taxes.

The effective date of these provisions would be for payroll periods beginning after December 31, 1983. A phase-in period would apply for health plans in which contributions are contractually fixed as of January 31, 1983.

Statutory exclusions for certain other fringe benefits

As a general rule, if an employer-provided fringe benefit program qualifies under certain statutory provisions of the Code, then the benefits provided under the program are excludable (generally, subject to dollar or other limitations) from the employee's gross income for income tax purposes. (The income tax exclusions also generally apply for payroll tax purposes.) Those costs which are excluded from the employee's income nonetheless are deductible by the employer (as are costs not so excluded), provided that they constitute ordinary and necessary business expenses.

The tax statute provides, among others, specific exclusions with respect to employer provision of (1) up to $50,000 of group-term life insurance; (2) up to $5,000 of death benefits; (3) accident or health benefits; (4) parsonage allowances; (5) certain benefits provided to members of the Armed Services; (6) meals and lodging for the convenience of the employer; (7) legal services; (8) commuting through use of a van pool; (9) employee educational assistance; and (10) dependent care assistance.

Tax treatment of nonstatutory fringe benefits

The Internal Revenue Code defines gross income as including "all income from whatever source derived" and specifies that it includes "compensation for services" (sec. 61). The U.S. Supreme Court has held that Code section 61 "is broad enough to include in taxable income any economic or financial benefit conferred on the employee as compensation, whatever the form or mode by which it is effected."

In actual practice, however, the economic benefit test has not been rigidly followed in all situations. Thus, where compensation is paid in some form other than cash, issues as to taxability of certain fringe benefits have been resolved by statutory provisions, regulations, and administrative rulings and practices which take account of several different factors.

The Economic Recovery Tax Act of 1981 extended through 1983 the moratorium on issuance of Treasury regulations relating to the income tax treatment of nonstatutory fringe benefits.

II. DESCRIPTION OF ADMINISTRATION PROPOSAL TO CAP EXCLUSION FOR EMPLOYER-PROVIDED MEDICAL CARE (S. 640)

Present Law

Exclusion for income and employment tax purposes

Under present law, amounts paid by an employer to a health plan for compensating an employee (through insurance or otherwise) for personal injuries or sickness are not includible in the employee's gross income for income tax purposes (Code sec. 106) or in the employee's wages for purposes of employer or employee social security (FICA), railroad retirement (RRTA), or unemployment insurance (FUTA) payroll taxes (secs. 3121(a)(2), 3231(e), and 3306(b)(2)).

Also, benefits paid to an employee under an employer health plan are generally excluded from gross income for income tax purposes, and from wages for employment tax purposes, if the benefits are paid directly or indirectly to the employee as reimbursement for expenses incurred by the employee, or the employee's spouse or dependents, for medical care (sec. 105(b)). However, benefits paid under certain self-insured medical reimbursement plans may be includible in the gross income of officers, 10-percent shareholders, and certain highly compensated individuals if the plans discriminate in favor of these individuals (sec. 105(h)).

Deductions for medical care expenses

A deduction generally is allowed to an employer as an ordinary and necessary business expense for employee compensation paid in the form of contributions to a health plan (sec. 162).

Individuals (whether or not employees) who itemize deductions may claim a deduction for their expenses for medical care, including premiums for health insurance, paid during the year to the extent that such expenses exceed five percent of the individual's adjusted gross income and are not reimbursed by insurance (sec. 213). The five-percent floor replaces the prior-law three-percent floor for taxable years beginning after 1982.

Medical care means amounts paid for (1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (2) transportation primarily for and essential to such medical care; and (3) insurance premiums to the extent that such insurance covers expenses of medical care (sec. 213(d)(1)). Under Treasury regulations, the itemized deduction is limited to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness. An expenditure which is merely beneficial to the general health of an individual or for the alleviation of physical or mental discomfort which is not related to some particular disease or defect is not an expenditure for medical care.[1]

Explanation of Provisions

In general

The bill would establish a maximum exclusion for employer contributions to an employee health plan providing for medical care. The maximum would apply for income tax purposes and for purposes of the employer's and employee's FICA and RRTA liability, the employer's FUTA liability, and income tax withholding.

The maximum would be $175 per month for family coverage for calendar year 1984. A correspondingly lower limit on the exclusion ($70 per month) would apply for "employee-only" coverage for 1984.[2] These exclusion limits would be indexed each year thereafter by the average of the Consumer Price Index for All Urban Consumers for the 12-month period ending on the June 30 prior to the calendar year in which the limits apply.

The amount of an employer contribution to a health plan with respect to coverage of an employee would be the cost of the coverage of the employee reduced by any contributions made by the employee for such coverage. Any cost of providing coverage under a plan allocable to worker's compensation or for a purpose other than the providing of medical care would not be considered as employer contributions to an employee health plan.

Under the bill, the amount of employer contribution exceeding the relevant dollar cap for a month (the "excess employer contribution") would be prorated according to the length of the payroll period. The excess employer contribution for a payroll period would be treated as compensation paid to the employee in cash on the earliest date on which any other compensation for such payroll period is paid to the employee or included in the employee's gross income.

Health plan definition

Health plans would be defined by the bill to include employer plans that provide (through insurance, reimbursement, or otherwise) to employees and their families the types of medical care that would be deductible if purchased by the individual employee. However, the bill would not apply to benefits under a plan for providing medical care for individuals in active service in the Armed Forces of the United States or for the families of such individuals.

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[1] See Regs, sec. 1.213-1(e)(1)(ii). For example, the Internal Revenue Service has held that payments for weight reduction or smoking prevention programs do not qualify as expenses for medical care under section 213 where participation in such programs was not for the purpose of curing any specific ailment or disease (Rev. Rul. 79-151, 1979-1 C.B. 116; Rev. Rul. 79-162, 1979-1 C.B. 117). However, in a subsequent letter ruling, the Revenue Service treated the costs of a weight reduction program as medical care expenses deductible under section 213 where two physicians had expressly prescribed such a program for purposes of treating and curing the taxpayer's hypertension, obesity, and hearing problems which were directly related to the taxpayer's excessive weight (IRS Ltr. Rul. 8004111, Oct. 31, 1979).

[2] In any case where an employee has coverage other than individual coverage, and the employee has no spouse or dependent who is actually covered by reason of the employee's coverage, the employee would have to notify the employer of such fact. For purposes of the bill, such an employee would be treated as having individual coverage.

The bill would prescribe rules for computing the cost of a health plan and of the employer contribution to a health plan. If a group of employees is offered a choice of coverage which differs from that offered to a second group of employees, each group would be treated as covered by a separate plan. Individuals whose primary health insurance coverage is under Medicare (title XVIII of the Social Security Act) would be treated as receiving different coverage from individuals whose primary health insurance coverage is not under Medicare.

Cost determination

The cost of coverage under a plan for a payroll period would be determined prior to the beginning of a payroll period and would be redetermined at least every 12 months. The cost of coverage would be redetermined whenever there were significant changes in coverage or in the composition of the group of employees covered. Under the bill, the employer would determine the cost of coverage separately for individual coverage and family coverage under each of the employer's plans.

The cost of coverage for a payroll period would be the aggregate annual cost for all employees covered under the plan divided by the number of such employees and further divided by the number of payroll periods in the year. The annual cost of providing coverage under a plan would be the cost to the employer of insurance for any insured coverage, plus all costs incurred by the employer with respect to noninsured coverage. Noninsured coverage means any coverage the risk of which is not shifted from the employer to a third party. Therefore, the liability incurred for benefit payments (those not covered by a third party) plus all other costs, including administrative costs, incurred with respect to the plan is considered a noninsured cost. In lieu of determining the actual amount of other costs, an employer could treat an amount equal to seven percent of the liability incurred for benefit payments which are not covered by a third party as equal to such other costs. If the cost to the employer of insurance reflects the employer's prior experience under the plan, an average cost of insurance based on premiums for the three immediately preceding years could be used.

If actual costs of coverage cannot be determined in advance, the cost of coverage would be based on a reasonable estimate. If such estimates are determined not to be reasonable and are lower than the actual cost of coverage, then the employer or multiemployer plan to which an employer makes contributions would be liable for the taxes that would have been imposed, computed using the actual cost of coverage. In this case, the taxes would be computed by assuming that the excess employer contribution had been included, for the calendar year in which the payroll period begins, in the taxable income of each employee. The computations would be based on the assumptions that the (1) employee is subject to the maximum rate of tax imposed upon individuals, (2) the individual's remuneration (including such excess) had not reached the maximum wage base for purposes of FICA taxes, and (3) the individual's remuneration for employment (including such excess) for the calendar year exceeded $6,000.

Multiemployer plans

The bill provides special rules for computing the employer's payroll tax and withholding tax liability with respect to employer contributions to a multiemployer health plan.[8] With respect to an employee for a payroll period, the excess employer contribution in this case would be equal to a fraction of each contribution made to the plan. The numerator of this fraction would be the excess employer contribution for one month (as determined by the multiemployer plan) and the denominator would be the total employer contributions for one month, both determined with respect to coverage of all employees under the plan. For this purpose only, the excess employer contribution could be determined on the basis of a single cost of coverage and a single dollar limit for both individual and family coverage. Such cost and limit each would be based on an average of the separate cost of coverage or the separate limit for each type of coverage (family or individual), with the average weighted to take into account the percentage of employees having each type of coverage.

For purposes of determining the employee's income and payroll tax liability, the amount of excess employer contributions would be determined by the multiemployer plan in the same manner as if the plan were the employer. That is, this liability would be based on a separate determination by the plan of the amount by which the cost of providing individual or family coverage exceeds the applicable limit. The bill would provide that each multiemployer plan which includes an employee health plan for which there are excess employer contributions for a calendar year must provide an information report to each employee with respect to whom such contributions to the plan were made during the calendar year. The report would have to be furnished by February 1 of the succeeding year and would have to include the amount of the excess employer contributions with respect to the employee for the calendar year and the amount of employer contributions that were treated by employers as excess employer contributions included in the gross income of the employee.

Employment tax amendments

If the taxes imposed on an employee by FICA or RRTA with respect to excess employer contributions which constitute wages exceed the portion of such tax which can be collected by the employer from the wages of the employee, then the employee would pay the excess. Income tax withholding liability on excess employer contributions would apply only to the extent that the amount can be deducted by the employer.

Effective Date

The provisions of the bill generally would apply to payroll periods beginning after December 31, 1983, in taxable years ending after such date.

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[8] A multiemployer plan is an employee welfare benefit plan (within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974) to which more than one employer is required to contribute and which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

In health plans in which employer contributions are fixed by terms of a legally binding contract in effect on January 31, 1983, the provisions of the bill would apply to the earliest of January 31, 1986, or the first date on which the amounts of the employer contributions are no longer fixed by the terms of the contract, or the first date on which the contract is or could be extended, renegotiated, or reopened or altered.

Revenue Effect

The bill is estimated to increase fiscal year budget receipts as follows:

[In billions of dollars]

	1984	1985	1986	1987	1988
Income tax	1.5	3.0	4.0	4.9	6.1
Payroll tax	.6	1.1	1.4	1.7	2.2
Total	2.1	4.1	5.4	6.6	8.3

III. OVERVIEW OF TAX TREATMENT OF CERTAIN STATUTORY FRINGE BENEFITS

In general

As a general rule, if an employer-provided fringe benefit program qualifies under certain statutory provisions of the income tax law, then the benefits provided under the program are excludable (generally, subject to dollar or other limitations) from the employee's gross income for income tax purposes. (The income tax exclusions also generally apply for payroll tax purposes.) Those costs which are excluded from the employee's income nonetheless are deductible by the employer (as are costs not so excluded), provided that they constitute ordinary and necessary business expenses (sec. 162).

The tax statute provides, among others, specific exclusions with respect to employer provision of (1) up to $50,000 of group-term life insurance; (2) up to $5,000 of death benefits; (3) accident or health benefits; (4) parsonage allowances; (5) certain benefits provided to members of the Armed Services; (6) meals and lodging for the convenience of the employer; (7) legal services; (8) commuting through use of a van pool; (9) employee educational assistance; and (10) dependent care assistance.

Nondiscrimination rules

Under present law, rules prohibiting discrimination in favor of owners, officers, shareholders and highly compensated employees are provided for many of different statutory fringe benefits. These rules generally prohibit discrimination as to eligibility to participate. A plan or program generally is required to meet the eligibility requirement by covering a classification of employees determined by the Internal Revenue Service not to result in prohibited discrimination. A self-insured medical reimbursement plan or group-term life insurance plan may also satisfy the requirement by covering a stated percentage of the employer's employees.

The eligibility rules generally permit employees covered by a collective bargaining agreement to be excluded from consideration if the benefits provided by the plan or program were the subject of good faith bargaining between the employer and employee representatives. The eligibility rules for self-insured medical reimbursement plans also provide that employees need not be taken into account if they have not completed three years of service, have not attained age 25, or are part-time or seasonal employees.

The present-law nondiscrimination rules applicable to certain types of fringe benefit plans and programs also prohibit discrimination as to contributions or benefits. With respect to self-insured medical reimbursement plans, present law specifically requires that all benefits available to officers, 10-percent shareholders, or highly compensated individuals must also be available to all other plan participants.

Under present law, if a plan is determined to discriminate in favor of employees who are officers, shareholders, or highly compensated, the otherwise applicable income exclusion generally is denied for all benefits provided under the plan, including those benefits provided for rank-and-file employees. (The nondiscrimination rules generally do not provide express guidance as to when an employee is considered highly compensated, or the extent of stock ownership required before an employee is considered a shareholder.) However, under a discriminatory self-insured medical reimbursement plan or group term life insurance plan, only those employees with respect to whom discrimination is prohibited are required to include amounts in gross income. Other employees retain the benefit of the income exclusion.

Group term life insurance

Under present law (sec. 79), the income exclusion for the cost of employer-provided group term life insurance is subject to several limitations: (1) the exclusion is limited to the cost of the first $50,000 of such insurance on the employee's life, computed pursuant to tables prescribed by the Treasury Department; (2) no exclusion is provided for any "key employee" (officers, five-percent owners, one-percent owners with compensation in excess of $150,000, and certain employee-owners) if the program discriminates in favor of key employees as to either eligibility to participate or the life insurance benefits actually provided under the plan; and (3) no exclusion is provided for self-employed individuals (sole proprietors or partners).

Death benefits

Present law generally excludes from a beneficiary's gross income certain benefits paid by or on behalf of an employer by reason of an employee's death (sec. 101(b)). This exclusion is subject to several limitations: (1) only the first $5,000 of benefits attributable to any one employee is eligible for the exclusion; (2) amounts which are income in respect of a decedent (e.g., uncollected salary or unused vacation pay) are not eligible for the exclusion; (3) no exclusion is provided for amounts with respect to which the employee had a nonforfeitable right to receive the benefits, unless the source of payment is a qualified pension, profit-sharing, or stock bonus plan or certain annuity plans; and (4) no exclusion is provided for amounts received under certain joint and survivor annuities where distribution to the participant had commenced prior to death. The exclusion generally is not available to self-employed individuals.

Accident and health benefits

Under present law, an employer's contributions to a plan providing accident or health benefits are excludable from the employee's income (sec. 105). No exclusion is provided for self-employed individuals.

Benefits actually paid under accident and health plans generally are includible in gross income to the extent attributable to employer contributions. However, payments unrelated to absence from work and reimbursements for costs incurred for medical expenses (within the meaning of sec. 213) are excluded from gross income. In the case of self-insured medical reimbursement plans (sec. 105(h)), no exclusion is provided for benefits paid to any employee who is an officer, 10-percent shareholder, or highly compensated if the program discriminates in favor of this group as to either eligibility to participate or the medical benefits actually provided under the plan.

Parsonage allowances

Present law permits a minister of the gospel to exclude from gross income the rental value of a home provided as a part of compensation, or a rental allowance paid as compensation to the extent used to rent or provide a home (sec. 107). The exclusion is subject to several restrictions: (1) the amount of the exclusion is limited to the rental value of the home or actual amounts paid to rent or provide a home; (2) the exclusion is available only if the home or rental allowance is paid as remuneration for services; and (3) the exclusion for rental allowance is available only if the employer designates such payment as a rental allowance in advance of payment.

Benefits provided to members of the Armed Forces

Present law permits military personnel to exclude a variety of in-kind benefits and cash payments from gross income. Specific exclusions apply to certain disability pensions (sec. 104(a)(4)); qualifying combat pay (sec. 112); mustering-out payments (sec. 113); and subsistence, housing, and uniform allowances, as well as the value of quarters or subsistence provided in kind (Regs. sec. 1.61-2(b)).

Meals and lodging for the employer's convenience

Present law excludes from gross income the value of certain meals or lodging furnished to an employee (or to the employee's spouse or dependents) by or on behalf of the employer for the convenience of the employer (sec. 119).

The exclusion for meals is available only if the meals are furnished (1) on the employer's business premises and (2) for the convenience of the employer.

The exclusion for lodging is available only if (1) the lodging is furnished on the employer's business premises; (2) the lodging is furnished for the convenience of the employer; and (3) the employee is required, as a condition of employment, to accept such lodging.

Legal services

Present law excludes from gross income employer contributions to a qualified prepaid legal services plan, as well as the value of any legal services received by, or amounts paid as reimbursement for legal services for, the employee, or the employee's spouse or dependents (sec. 120). Also, the exclusion is available to self-employed individuals covered by qualified prepaid legal services plans.

This exclusion is subject to several limitations: (1) the program may provide only for personal (i.e., nonbusiness) legal services; (2) no exclusion is available if the program discriminates in favor of employees who are officers, shareholders, or highly compensated, as to either eligibility to participate or the benefits provided under the plan; and (3) no more than 25 percent of the employer contributions to the plan may be attributable to the group consisting of employees (and their spouses and dependents) who own more than five percent of the stock or of the capital or profits interest in the employer.

This exclusion is scheduled to terminate for taxable years ending after 1984.

Van pooling

Present law excludes from an employee's gross income the value of certain employer-provided transportation between an employee's residence and place of employment (sec. 124).

This exclusion is subject to several limitations: (1) the exclusion is available only for transportation furnished through use of a commuter van; (2) no exclusion is provided if the van-pooling arrangement discriminates in favor of employees who are officers, shareholders, or highly compensated; and (3) no exclusion is permitted for self-employed individuals (sole proprietors and partners).

The exclusion for van pooling is scheduled to terminate for van pooling provided in taxable years beginning after 1985.

Employee educational assistance

Present law excludes from an employee's gross income amounts paid for employer-provided educational assistance pursuant to a qualifying educational assistance program (sec. 127). Also, the exclusion is available to self-employed individuals (sole proprietors or partners).

The exclusion is subject to several limitations: (1) qualifying educational benefits are limited to the cost of tuition, fees, and similar payments as well as the cost of books, supplies, and equipment (i.e., no exclusion is provided for the costs of meals, lodging, or transportation); (2) no exclusion is provided for educational assistance furnished for courses involving sports, games, or hobbies; (3) no exclusion is provided for educational assistance furnished to an employee's spouse or dependents; (4) no exclusion is provided if the program discriminates in favor of employees who are officers, shareholders, or highly compensated; (5) no exclusion is provided if more than five percent of the total benefits paid is for the group consisting of employees who own more than five percent of the stock or of the capital or profits interest in the employer (or their spouses or dependents); and (6) the educational assistance program may not be part of a cafeteria plan.

This exclusion is scheduled to terminate for taxable years beginning after 1983.

Dependent care assistance

Present law excludes from an employee's gross income amounts paid or incurred by an employer for dependent care assistance provided under a qualified dependent care assistance program (sec. 129). Also, the exclusion is available to self-employed individuals (sole proprietors or partners).

This exclusion is subject to several limitations: (1) the amount excluded may not exceed the employee's earned income (or, if the employee is married, the lower of the earned income of the employee or the employee's spouse); (2) the exclusion is only provided for expenses for household services or care of qualifying individuals (dependents under the age of 15 or physically or mentally incapacitated dependents or spouses) which are incurred to enable the taxpayer to be gainfully employed; (3) no exclusion is provided for amounts paid for qualifying services rendered by the employee's dependent or any child of the employee who is under the age of 19; (4) no exclusion is provided if the dependent care assistance program discriminates in favor of employees who are officers, owners, or highly compensated individuals (or their dependents); and (5) no exclusion is provided if more than 25 percent of the total benefits paid are for the group consisting of employees who own more than five percent of the stock or of the capital or profits interest in the employer (or their spouses or dependents).

Cafeteria plans

Under a cafeteria plan, an employee may choose from a package of employer-provided fringe benefits, some of which are taxable (e.g., group-term life insurance in excess of $50,000) and some of which are nontaxable (e.g., health and accident insurance). Under present law, the mere availability of cash or taxable benefits under a cafeteria plan will not cause an employee to forfeit an otherwise applicable income exclusion (sec. 125). Thus, benefits generally are excluded to the extent that nontaxable benefits are elected.

No exclusion is permitted, however, if the cafeteria plan discriminates in favor of highly compensated individuals as to eligibility or as to benefits or contributions. A highly compensated individual includes an officer, a 5 percent shareholder, a highly compensated individual, or a spouse or dependent of any of the preceding individuals.

Voluntary employees' beneficiary associations

Under present law, the income of a voluntary employees' beneficiary association (VEBA) is exempt from Federal income tax provided that (1) the VEBA provides for the payment of life, sick, accident, or other benefits to members and dependents; (2) substantially all of the operations are to provide such benefits; and (3) no part of the VEBA's net earnings inure (other than through such payments) to the benefit of any private shareholder or individual (sec. 501(c)(9)).

Benefits which may be provided by a VEBA include life, sick, or accident benefits and other similar benefits intended to safeguard or improve the health of a member or member's dependents or to protect against a contingency that interrupts or impairs a member's earning power. For example, such benefits include vacation benefits, vacation facilities, subsidized recreational activities, child care facilities, and job adjustment allowances. (Reg. sec. 1.501(c)(9)-3(e)).

Under Treasury regulations, a VEBA may not discriminate as to eligibility or as to benefits in favor of officers, shareholders, or highly compensated individuals. (Reg. sec. 1.501(c)(9)-2(a)).

Present law permits an employee receiving cash or noncash benefits from a VEBA to exclude the value of the benefit from gross income to the extent otherwise permitted by specific Code provisions granting income exclusions. (Reg. sec. 1.501(c)(9)–6).

Similar rules apply to trusts for the payment of supplemental unemployment benefits (sec. 501(c)(17)).

IV. OVERVIEW OF TAX TREATMENT OF NONSTATUTORY FRINGE BENEFITS

Background

The Internal Revenue Code defines gross income as including "all income from whatever source derived," and specifies that it includes "compensation for services" (sec. 61). Treasury regulations provide that gross income includes compensation for services paid other than in money (Reg. sec. 1.61-1(a)). Further, the U.S. Supreme Court has stated that Code section 61 "is broad enough to include in taxable income any economic or financial benefit conferred on the employee as compensation, whatever the form or mode by which it is effected."[4]

In actual practice, however, the "economic benefit" test has not been rigidly followed in all situations. Thus, where compensation is paid in a form other than cash, issues as to the taxability of certain fringe benefits have been resolved by statutory provisions, regulations, and administrative rulings and practices which take account of several different factors.

As described in Parts II and III of this pamphlet, some fringe benefits, such as the providing of medical care by an employer for its employees, are expressly excluded from gross income, generally within certain limitations, by particular provisions of the Code. In addition, exclusions for other fringe benefits have been based on judicial authority or on administrative practice. For example, some economic or financial benefits furnished as compensation have been treated as excluded from income on the basis of *de minimis* principles; that is, accounting for some occasional benefits of small value may be viewed as unreasonably burdensome or administratively impractical. Other items have been treated as excluded in light of a combination of valuation difficulties and widely held perceptions that the particular items should not be taxed as income.

1975 Treasury discussion draft

In 1975, the Treasury Department issued a discussion draft of proposed regulations[5] which contained a number of rules for determining whether various fringe benefits constitute taxable compensation. The discussion draft was withdrawn by the Treasury Department on December 28, 1976.[6] Thus, the question of whether, and what, employee fringe benefits result in taxable income generally continued to depend on the facts and circumstances in each individual case.

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[4] *Commissioner* v. *Smith*, 324 U.S. 177, 181 (1945). *See also Commissioner* v. *Glenshaw Glass Co.*, 348 U.S. 426, 429-30 (1955) ("Congress applied no limitations as to the source of taxable receipts, nor restrictive labels as to their nature. And the Court has given a liberal construction to this broad phraseology in recognition of the intention of Congress to tax all gains except those specifically exempted.")

[5] 40 Fed. Reg. 4118 (Sept. 5, 1975).

[6] 41 Fed. Reg. 5634 (Dec. 28, 1976).

The 1975 discussion draft proposed a "safe harbor" (i.e., nontaxable treatment) for fringe benefits meeting all of three tests: (1) the goods or services provided to the employee were owned or provided by the employer in connection with a regular trade or business; (2) the employer incurred no substantial incremental costs in furnishing the goods or services to the employee; and (3) the goods or services were made available to employees on a nondiscriminatory basis. Fringe benefits not qualifying under the safe harbor would have been evaluated in terms of a nine-part facts and circumstances test, with no single factor deemed to be controlling. In addition, the discussion draft provided a *de minimis* rule exempting from taxation fringe benefits of little value.

If an item was required to be taken into income under the 1975 discussion draft, the amount includible in gross income constituted the amount the employee would have had to pay for the goods or services on an arm's-length basis (i.e., fair market value).

Ways and Means Task Force discussion draft bill

On January 22, 1979, the Task Force on Employee Fringe Benefits of the House Committee on Ways and Means issued a discussion draft report and bill on fringe benefits.[7] No further action was taken by the Ways and Means Committee on the Task Force Report. The Task Force discussion draft bill would have excluded from gross income certain fringe benefits that qualified under either (1) a safe harbor test, (2) a convenience of the employer test, (3) a *de minimis* test, or (4) regulations issued by the Treasury. Any other fringe benefits received by an employee would be includible in gross income at fair market value (less any amount paid by the employee for the benefits).

Under the safe harbor test in the Task Force bill, a fringe benefit would be excluded from gross income if: (1) it is made available to employees generally or to a reasonable classification of employees, (2) the employer incurs no substantial incremental cost in providing the fringe benefit, and (3) the total value of all fringe benefits received during the taxable year by the employee is not substantial, either in absolute terms or relative to the amount of compensation of the employee.

The convenience of the employer test would exclude from gross income fringe benefits made available primarily for the purpose of facilitating the employee's performance of services for the employer.

Under the *de minimis* rule in the Task Force bill, a fringe benefit would be excluded from gross income if its value is so small as to make accounting for it unreasonable or administratively impractical.

1981 Treasury discussion draft

On January 15, 1981, the Treasury forwarded to the House Committee on Ways and Means a revised "discussion draft" of proposed regulations on the tax treatment of fringe benefits.[8] This discussion draft was not reviewed by the Secretary of the Treasury and was not published in the Federal Register.

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[7] House Committee on Ways and Means, Discussion Draft Bill and Report on Employee Fringe Benefits (Comm. Print 1979).

Under the 1981 discussion draft, the value of property, services, or facilities furnished by an employer in connection with the performance of services by an employee generally would be included in the employee's gross income. The value of any fringe benefit included in gross income would be the amount by which the fair market value of the item or its use exceeds any amount paid by the employee for the item or its use.

Certain exceptions to the general rule would have been provided. Fringe benefits consisting of items furnished by an employer with the specific intent either to enable or facilitate the performance of employment services by the recipient would be excluded from gross income. In addition, certain items would be excluded from gross income for reasons of administrative convenience, which would be determined on the basis of the facts and circumstances.

Finally, the 1981 discussion draft would exclude from gross income nondiscriminatory free or discount parking provided to employees, and occasional noncash gifts of up to $25 in value per gift.

Moratorium on issuance of regulations

Public Law 95-427, enacted in 1978, prohibited the Treasury Department from issuing prior to 1980 final regulations relating to the income tax treatment of fringe benefits. That statute further provided that no regulations relating to the treatment of fringe benefits were to be proposed that would be effective prior to 1980. Public Law 96-167, enacted in 1979, extended the moratorium on issuance of fringe benefit regulations through May 31, 1981. Public Law 97-34 (the Economic Recovery Tax Act of 1981) extended the moratorium through December 31, 1983.

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[8] The January 15, 1981 discussion draft was reprinted in various publications, including Bureau of National Affairs, Daily Executive Report (Jan. 16, 1981), at p. J-14.

V. BACKGROUND DATA AND ISSUES RELATING TO TAX TREATMENT OF CERTAIN FRINGE BENEFITS

A. Revenue Implications

Table 1 below shows the increased revenues which would result from terminating the present-law exclusions for the principal statutory fringe benefits described in the previous portion of this pamphlet.[9] This table does not contain information on nonstatutory fringe benefits, although the tax treatment of these items may have substantial revenue implications.

Each entry in the table has two lines. The first represents the gain in income tax revenue which would result if the benefit were included in gross income; these figures are taken from the 1983 tax expenditure pamphlet published by the Joint Committee on Taxation.[10] The second line shows the implications for social security tax receipts of the employment tax treatment of these items.

In terms of revenue effect, health insurance is the largest fringe benefit shown in this table, followed by group term life insurance. Each of the other fringe benefits shown in this table have less revenue impact.

Table 1.—Effects of Including Certain Statutory Fringe Benefits in the Federal Income Tax Base and the FICA Tax Base

[In billions of dollars]

Item	1983	1984	1985	1986	1987	1988
1. Employer contributions for medical insurance:						
Income tax	18.6	21.3	24.3	27.7	31.6	36.0
FICA	6.1	7.6	8.8	10.0	11.3	13.3
2. Premiums on group term life insurance:						
Income tax	2.1	2.2	2.5	2.7	3.0	3.3
FICA	.3	.5	.8	.9	.9	1.0
3. Contributions to prepaid legal services plans:						
Income tax	(1)	(1)	(1)			
FICA	(1)	(1)	(1)			

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[9] This pamphlet does not describe the statutory exclusion for employer contributions to qualified pension, profit-sharing or stock bonus plans, qualified annuity plans, or tax-sheltered annuity plans, or any other income tax items which may be considered fringe benefits.

[10] Staff of the Joint Committee on Taxation, "Estimates of Federal Tax Expenditures for Fiscal Years 1983-1988", (JCS-4-83), Comm. Print (March 7, 1983).

Table 1.—Effects of Including Certain Statutory Fringe Benefits in the Federal Income Tax Base and the FICA Tax Base—Continued

[In billions of dollars]

Item	1983	1984	1985	1986	1987	1988
4. Employer educational assistance:						
Income tax	(1)	(1)				
FICA	(1)	(1)				
5. Employer provided child care:						
Income tax	(1)	(1)	.1	.1	.1	.2
FICA	(1)	(1)	(1)	(1)	(1)	.1
6. Employee meals and lodging (other than military):						
Income tax	.7	.7	.8	.9	.9	1.0
FICA	.2	.2	.2	.3	.3	.3
7. Benefits and allowances to Armed Forces personnel:						
Income tax	2.2	2.2	2.4	2.5	2.7	2.8
FICA	(2)	(2)	(2)	(2)	(2)	(2)

[1] Less than $50 million.
[2] Not available.

B. Growth in Fringe Benefits

Tables 2 and 3 present data from the national income accounts on the growth between 1950 and 1981 of employer contributions to group health insurance and group life insurance, the two largest generally available statutory fringe benefits which are shown in table 1, measured in terms of revenue effect.

Table 2 shows that during this period, these two benefits have grown considerably faster than wage and salaries. Group health insurance grew from 0.5 percent of wages in 1950 to 3.7 percent of wages in 1981, and group life insurance contributions increased from 0.2 percent of wages in 1950 to 0.4 percent of wages in 1981.

Group health insurance has grown at a much faster rate than group life insurance. Group health insurance has continued to grow throughout the period, while group life has been approximately the same percentage of wages since 1965. Although many factors have influenced the growth of these two fringe benefits, it should be noted that the tax treatment of group term life insurance changed in 1964, when a limit was placed on the amount of employer contribution which could be excluded from gross income for income tax purposes.

Table 3 shows another way of examining the growth in employer contributions to health and life insurance during this period. These figures compare the increase in wages to the increase in the fringe benefit during this period.

Between 1950 and 1955, for example, health contributions increased 1.5 cents for every dollar of increase in aggregate wages. By the end of the period, health benefit contributions increased approximately 4.7 cents for each dollar of increase in wages. Thus, there was a significant acceleration in the growth of health benefits relative to wages over the 1950 to 1981 period, although this trend stabilized during the 1970s.

In contrast, increases in group term life insurance as percentage of wage increases declined over the 1950-1981 period. During the first five years, group life insurance contributions increased 0.5 cents for every dollar of wage increase. This figure reached a peak during the last part of the 1950s. Since that time, however, the increase in life insurance as a percentage of wage increases declined significantly, so that by 1981 these contributions increased by only 0.2 cents for every dollar of wage increases.

Table 2.—Employer Contributions to Group Health and Life Insurance as Percentage of Wages and Salaries, United States, 1950–81

[In percent]

	Group health	Group life
1950	0.5	0.2
1955	.8	.3
1960	1.3	.4
1965	1.6	.5
1970	2.2	.5
1975	3.0	.5
1980	3.6	.5
1981	3.7	.4

Source: Computed from U.S. Department of Commerce data.

Table 3.—Increase in Total Employer Insurance Contributions as Percentage of Total Increase in Wages, United States, 1950–81

[In percent]

	Group health	Group life
1950–55	1.5	0.5
1955–60	2.8	.9
1960–65	2.7	.6
1965–70	3.3	.7
1970–75	4.7	.6
1975–80	4.5	.5
1980–81	4.7	.2

Source: Computed from U.S. Department of Commerce data.

C. Issues Related to Tax Treatment of Fringe Benefits

In general

1. Present law imposes a higher tax liability on an individual who receives no employer fringe benefits (whether or not the purchases the item individually) than on another individual with the same amount of income partially received in the form of tax-free fringe benefits. Some have argued that this is inequitable.

2. By excluding certain fringe benefits from taxation, present law may encourage greater consumption of the benefit than would occur in the absence of a tax system and higher marginal tax rates on the income which remains taxable. Some argue that this causes an inefficient distortion in the ability of consumers to obtain maximum satisfaction from available resources and interferes with incentives to work, save, and invest; others argue that the greater consumption of certain items should be encouraged because this provides a significant benefit to society which individuals do not take into account when making their consumption decisions.

3. By excluding certain fringe benefits from taxation, present law avoids administrative difficulties which could be encountered in valuing noncash forms of compensation.

4. Some argue that rules which prohibit discrimination in favor of owners and highly compensated employees in the provision of tax-free fringe benefits are sufficient to prevent abuse. Others argue that these rules do little to limit the amount of income excluded from tax, and, thus, the revenue loss and inequity resulting from this treatment.

Administration proposal to cap exclusion for employer-provided medical care

1. Some argue that the present unlimited exclusion for employer health plan contributions encourages inefficient expansion of coverage that encourages consumers to treat medical care as if it were free. This, in turn, increases the use of medical services which may have little or no value to the consumer or are more expensive than necessary. Even with a limit on the exclusion, employers will provide services which enable them to reduce the cost of their health plans, but there is little evidence that unlimited health care spendng *per se*, as encouraged by present law, improves health status. Others argue that any limit on the exclusion would discourage covrage among low-income employees who are least able to afford it, would discourage the use of relatively new services which could educe health costs significantly in the long run, and would inrease out-of-pocket medical expenses for those who become sick.

2. Some argue that a limit which is uniform across all employers unfair because it does not recognize significant variations by egion, age, and health status in the cost of providing health serves. Thus, employees who belong to high-cost groups would pay igher taxes than other employees receiving the same coverage nd belonging to low-cost groups. Others argue that a uniform mit is consistent with other important features of the tax statute, ch as the brackets and the personal exemption, which are not adsted for differences in costs of purchasing goods and services, and at high costs in certain regions may simply result from an exces-

sive amount of insurance coverage in those areas, rather than from differences in the prices of medical supplies and in wages paid to health care workers.

3. Some argue that significant administrative difficulties are presented by the taxation of benefits provided by multiemployer plans and self-insured plans. Others argue that exempting multiemployer or self-insured plans would result in inequitable administration of the tax laws and, thus, these administrative difficulties are justified.

4. Some argue that the effective date of any proposal to tax employer health plan contributions should give special treatment to those whose benefits are determined under a collective bargaining contract, while others argue that this would be unfair to other affected workers.

Moratorium on fringe benefit regulations

Some argue that the moratorium on the issuance of fringe benefit regulations should be extended at least for another two-year period. In light of disagreements as to the proper tax treatment of certain nonstatutory fringe benefits, it is argued that there should be additional time to consider the issue of subjecting to taxation benefits which are widely available to many workers, which many taxpayers simply do not view as either equivalent to cash or taxable compensation, and for which there would be substantial valuation and recordkeeping problems for employers and employees alike.

Others argue that the moratorium should not be extended beyond 1983, and that the Congress either should enact guidelines for the exclusion or taxability of particular types of common nonstatutory employee fringe benefits (e.g., discounts on employer-produced goods or services, free transportation provided to employees in the transportation industry, subsidized or free parking and cafeterias, etc.), or should permit the Treasury to continue its efforts to develop such rules by regulation. It is argued that extending the moratorium would encourage increased use of such benefits in lieu of cash compensation, with corresponding loss in revenue and inequality of treatment between employees of industries which can provide such benefits at little or no cost and employees of industries, for example, whose products are not consumer goods. Also, questions as to the applicability of the moratorium to the taxation of particular fringe benefits have caused confusion and uncertainty for taxpayers and the Internal Revenue Service, as well as the lack of uniform treatment among similarly situated taxpayers.

Senator PACKWOOD. We are starting hearings this morning on the administration's proposal on the health cap and testimony on fringe benefits in general.

Our first two witnesses today are Buck Chapoton, the Assistant Secretary for Tax Policy, and Dr. Rubin, the Assistant Secretary for Planning and Evaluation.

Buck, I know you've got to meet with the President at 11, so if you want to, start with your statement. Abbreviate it if you feel you would like to, I think there will be a few questions but we will try to get you out as soon as possible.

STATEMENT OF HON. JOHN E. CHAPOTON, ASSISTANT SECRETARY FOR TAX POLICY, DEPARTMENT OF THE TREASURY, WASHINGTON, D.C.

Mr. CHAPOTON. Thank you, Senator.

I will abbreviate it, because we've got three major subjects here to cover. Let me go through them rather hurriedly.

The first subject is S. 640, which would limit the amount of exclusion from gross income of employer contributions to health plans. Under present law, of course, an employee's gross income does not include any contribution by the employer to health plans that provide compensation for personal injuries or sickness. The exclusion from the employee's income of employer payments to health care plans encourages employers to provide and employees to accept a portion of that compensation in the form of health insurance.

Excluding employer contributions creates an inequity between individuals covered by employer group health plans and those who are not covered, since the latter group must pay for health care with after-tax dollars while the health care of the former group is provided with pretax dollars. The cost of the exclusion, both in terms of foregone Federal revenues and inequities created between various taxpayers has been accepted until now as the price to accomplish the important social goal of providing individuals with adequate health insurance protection.

The tax benefit attributable to receiving compensation in the form of this tax-free health care premium rather than cash is substantial. It is so substantial that employers are encouraged to provide and employees are encouraged to accept extraordinarily generous health care insurance, often with no internal controls on costs and utilization of services by the employee. The administration supports the principle that individuals should be encouraged to obtain adequate health insurance, but a careful examination of the exclusion indicates it is being used to provide more than adequate health insurance.

The purchase of excessive amounts of health insurance has had a detrimental effect on health care costs, and for this reason the administration has proposed in our fiscal 1984 budget to limit the exclusion from income to $175 per month for family coverage and $70 a month for individual coverage. We think these levels would permit employees to obtain adequate insurance coverage tax-free while requiring them to bear some of the cost of providing more comprehensive insurance plans. S. 640 was introduced by Chairman Dole at the administration's request and does contain our proposals in this regard.

The $175 per month for family and the $70 per month for individuals are indexed to the CPI for years after 1984. The amount of excess contribution to a health plan over the limit, as indexed, would be treated as compensation paid to the employee in cash, and therefore it would be subject to the normal rules relating to withholding and payroll taxes.

I provide in my written testimony a lot of the details on how you determine the value to the employee of the coverage, how we deal with self-insurance plans, and how we deal with multiemployer plans. I will not go through those matters with the committee now.

There are some problems. We do think that S. 640 addresses the problems. They have been carefully thought through, and we think the problems are handled and that the plan is easily administered and is a sound plan.

Let me switch now, Mr. Chairman, to the taxation of fringe benefits which you asked us to comment on because the moratorium on further regulations on nonstatutory fringe benefits expires at the end of this year.

I have a rather lengthy statement. This is a difficult area that we and the committees have dealt with before. I will summarize just some of the key points in our statement.

The first thing to keep in mind is that the taxation of fringe benefits can be divided into two parts. One is the statutory fringe benefit area, those fringe benefits which Congress has addressed and has decided should be nontaxable to promote some nontax social policy. Examples of this, of course, are pension plans, group term life insurance, health care plans, medical care reimbursements, and the like.

The second part of the current law on the tax treatment of fringe benefits relates to those fringe benefits which are not specifically addressed by anything in the statute. The taxability of these nonstatutory fringe benefits is currently governed by the general definition of gross income in the code; that is, section 61.

Despite the fact that numerous Treasury regulations and numerous court decisions have held that compensation under section 61 includes compensation in whatever form paid—cash or otherwise—there is a public perception that a number of in-kind benefits received from an employer are not subject to tax. The belief that a wide variety of nonstatutory fringe benefits do not constitute income and are not taxable results in employers and employees seeking to arrange compensation packages providing for more compensation to be paid as nonstatutory fringe benefits, in an attempt to rely on what is under the law a mistaken belief that they are not taxable. This places employers who pay wages in cash at a disadvantage, and we think it erodes the tax base and public confidence in the tax system as well. We do think that Congress should address the question of the proper tax treatment of nonstatutory fringe benefits.

The administration of the tax laws in this area has required drawing some very fine distinctions. One distinction is that between working conditions and compensation. An employee often receives personal benefit through providing certain working conditions that are offered to him, but the Internal Revenue Service has consistently taken the position that working conditions are not part of compensation. But the distinctions in arriving at and applying that rule are not always clear. Also, it is difficult to determine whether a benefit provided by an employer to an employee is a gift or compensation.

In 1921 the Internal Revenue Service said that free personal railroad passes issued to employees were gifts rather than compensation, and that has grown into the belief that many items such as airline passes are also gifts and are therefore nontaxable.

In the early seventies the IRS attempted to deal with the area of nonstatutory fringe benefits and issued a set of regulations that has gone through a traumatic history over the last decade—more than a decade—resulting in the imposition of a moratorium on further action by the Treasury and the Internal Revenue Service in attempting to draw the line between taxable and nontaxable benefits. That moratorium is still in effect but expires at the end of this year.

We think the moratorium has perpetuated inconsistencies in the administration of the tax law. The Service, unable to provide agents and the public with clear statements of the proper treatment of nonstatutory fringe benefits, has left everyone confused and this, obviously, has an adverse impact on compliance.

We do not think it is possible for the Treasury Department to clarify the tax status of nonstatutory fringe benefits without legislative action. There are a number of benefits which have long been assumed to be nontaxable, but which cannot be excluded by regulation under existing law. Primary examples of these would be the airline passes, tuition remission or reimbursements, and merchandise discounts. We think the Congress should deal with these problems by legislation. We cannot deal with them by regulation.

We think that alternative approaches to those that have been tried in the past should be considered. One approach would of course be to simply write in statutory exclusions for those nonstatutory fringe benefits which the public has considered nontaxable for a substantial period of time. This would avoid controversy, but it would be a substantial departure from the general feeling that we exclude certain benefits to promote a desirable social policy. It is difficult to see the social policy argument behind excluding income such as airline passes, tuition remission, or store discounts. That would simply grant preferred tax treatment to certain employees in certain industries and professions. We are also concerned that when you start down the road of a statutory exclusion list, that list would grow quite dramatically. Nevertheless, we think it might be preferable to make that attempt rather than to extend the moratorium.

An alternative might be to address two of the elements that have caused concern in the fringe benefit area in the past. The first element is the determination of the fair market value of the fringe benefit. The second is the hardship or perceived hardship imposed on employees when they must obtain cash to pay taxes on inkind benefits that cannot be converted into cash.

Some commentators have sought to address the fair market value problem by using the employers' allocated costs. We are not convinced that that is substantially less difficult than determining fair market value, but we do think it might be worthwhile to consider allocated costs plus an assumed rate of return on the costs as a way to arrive at fair market value.

We think these valuation problems, might be reduced if we dealt with the problem at the employer level—that is, a tax at the employer level. That would remove the need to allocate the value of fringe benefits to particular employees. In many cases the employer knows how much benefit he is providing but doesn't know how to allocate that to particular employees. It would also address the problem, of course, of employees who cannot convert their inkind compensation into cash. We could deal with this at the employer level either by disallowing the business deduction or by simply putting some type of excise tax where tax-free benefits had been provided to employees.

We think addressing it at this level would be fair. Such a solution would simply say that if the employer wishes to provide compensation designed to avoid tax, he cannot have it both ways. He cannot design compensation that permits employees to pay no tax while still retaining the full tax benefits of the deductions for himself. The system cannot afford the growth of this inconsistent treatment by employers.

These two approaches would have their own problems, however, and in our statement I go through some of the problems that we think would be presented by dealing with the fringe benefit area at the employer level. We suggest that those problems might be less than would otherwise be presented by dealing with the problem at the employee level.

And finally, Mr. Chairman, you asked us to address the cafeteria-plan question. A cafeteria plan is an arrangement by which an employer can enable his employees to choose among cash or a variety of statutory or nonstatutory fringe benefits.

Without the addition of section 125 to the code in 1978, the option of an employee to receive cash or one of these other benefits would have caused that employee to be taxed on the benefit under the doctrine of constructive receipt, because he could have received cash. Section 125 says that that is not a problem, and therefore it allows employers to design plans offering taxable and nontaxable benefits. And that is the cafeteria plan, allowed by section 125.

Prior to section 125 there was a practical limit on the extent to which employers could provide compensation to employees in the form of nontaxable fringe benefits. Simply, the employees themselves would resist providing benefits in a nontax mode if they could not enjoy that benefit. So there was a practical limit on the extent to which tax-free statutory benefits could be obtained.

The establishment of the cafeteria plan delivery system, however, eliminates this "employee jealousy," as we call it, as a constraint upon the use of fringe benefits as a principal means of compensation. We are concerned about the effect of that change in the law.

We suggest in our testimony, through an example, that there is a possibility of significant abuse here. The example we take is that if all employees are entitled to reduce their salary by 30 percent and get a range of benefits or cash, that some employees will take the full benefit—and as an example we use medical reimbursement and dependent care assistance—while other employees will take cash. In the example, where we have two employees earning $50,000 and two earning $10,000, one employee takes tax-free benefits of a full $15,000—that is 30 percent of his $50,000—while the others take $1,500 in tax-free benefits. This plan would not be discriminatory even though the higher paid employees have $15,000 and the lower paid employees would receive only $1,500 in tax-free benefits. We think this presents a problem in that it does de facto discriminate and that it is made possible only because of the existence of the cash option.

We think that if the cash or taxable benefit option exists, that there ought to be a dollar limit on the amount of the cash option. Otherwise we think that we are looking at a very expanded use of tax-free benefits as compensation. We do go into some detail on that in our testimony, but I think I'll shut it down here at this time, Mr. Chairman.

Thank you.

[The prepared statement of John E. Chapoton follows:]

PREPARED STATEMENT OF HON. JOHN E. CHAPOTON, ASSISTANT SECRETARY (TAX POLICY), DEPARTMENT OF THE TREASURY

Mr. Chairman and members of the committee, I am pleased to appear before you today to present the Treasury Department's views on S. 640, which would limit the amount of the exclusion from the gross income of employees for employer contributions to health plans, and on the tax treatment of fringe benefits in general.

S. 640

Background

Under present law, an employee's gross income does not include contributions by the employer to health plans that provide compensation to employees for personal injuries or sickness. The exclusion from the employees' income of employer payments to health care plans encourages employers to provide and employees to accept a portion of compensation in the form of health insurance. Employees are benefited by the exclusion because they do not have to pay income or social security taxes on the value of the health insurance. Employers benefit because it costs them less to compensate employees since they do not have to pay unemployment taxes or the employer's share of social security taxes on the value of the insurance; employers also may be able to reduce the amount of pretax compensation paid, since the employee receives a greater after-tax share of the pretax compensation.

Excluding employer contributions to health plans from gross income creates an inequity between individuals covered by employer health plans and those who are not so covered. The latter group must pay for their health care with after-tax dollars, while the health care of the former group is provided with pretax dollars. In addition, the exclusion encourages employees to receive large amounts of their compensation in the form of tax-free health insurance. This has led to a significant increase in the amount of compensation that is not subject to tax and, therefore, to a substantial loss of Federal revenues, including revenues for funding social security benefits. The costs of this exclusion, both in terms of foregone Federal revenues and the inequities created between various taxpayers, have been accepted until now as the price paid to accomplish the important social goal of providing individuals with adequate health insurance protection.

The tax benefit attributable to receiving compensation in the form of tax-free health care premiums rather than cash is so substantial that employers are encouraged to provide, and employees are encouraged to accept, extraordinarily generous health insurance coverage, often with no internal controls on costs and utilization of services by the employee. Such packages provide insurance coverage far in excess of the amount reasonably needed to protect an employee from financial hardship in the event of personal injury or sickness.

The proliferation of overly comprehensive employer-paid health care plans without internal cost controls is a contributing factor in the rapid increase in health care costs in recent years. Some insurance plans are so generous that employees bear little, if any, of the cost of doctors' visits or hospital services. Without any costs imposed on them, the employees tend to overuse doctor and hospital services and medical tests. Overuse increases both the cost of each service and the number of services utilized by each individual. The result is an increase in health care costs.

This Administration supports the principle that individuals should be encouraged to obtain adequate health insurance. However, a careful examination of the exclusion provided for employer contributions to health care plans indicates it is being used to provide much more than adequate health insurance. The purchase of excessive amounts of health insurance has had detrimental effects on health care cost. For this reason, the Administration has proposed in its fiscal year 1984 budget to limit the exclusion from income for employer contributions to health plans to $175 per month for family coverage and $70 per month for individual coverage. These levels should permit employees to obtain adequate insurance coverage tax-free, while requiring them to bear some of the costs of providing more comprehensive insurance plans.

S. 640 is the bill introduced by Senator Dole at the Administration's request to enact the proposed limits on the exclusion for employer contributions to health plans for employees. For 1984, as mentioned, these limits are $175 per month for family coverage or $70 per month for individual coverage for each employee. For years after 1984, the monthly dollar limits will be adjusted to reflect changes in the Consumer Price Index. The amount of any excess employer contribution for a payroll period is treated as compensation paid to the employee in cash on the same date as other compensation for the same payroll period is paid or otherwise included in the employee's income. Thus, the normal rules relating to withholding and payroll taxes will apply to the amount of any excess employer contributions.

The amount of an employer's contributions to a health plan with respect to an employee is defined as the cost of coverage of the employee under the plan reduced by any contributions made by the employee for such coverage. The cost of coverage of employees under a plan is determined separately for family coverage and individual coverage. For a particular employee the cost of coverage is the average cost per employee of providing coverage for all employees having the same type of coverage (*i.e.*, individual or family coverage).

In some cases, an employer will know in advance the exact cost of providing coverage for his employees and can determine the actual amount of excess employer contributions, if any, prior to the beginning of any payroll period. For examble, an employer that purchases an insurance policy for an employee for a premium that is fixed in advance will be able to determine exactly what his employer contributions will be for the term of the policy. However, in many instances, employers do not know the exact cost of providing coverage for their employees until after the close of a payroll period. For example, an employer may be self-insured or may pay premiums that are retroactively adjusted based on the experience of the insurer with his employees. In order to avoid the confusion and hardship that would occur if retroactive changes were made in an employee's gross income for a payroll period, S. 640 provides that where the exact cost of coverage is not fixed in advance, the amount of an employee's income due to excess employer contributions will be fixed by the employer's estimate, made prior to the payroll period, of the cost of providing coverage. The employee's income will not be charged to reflect actual costs determined later, even if the actual cost of providing coverage turns out to be substantially higher or lower then the estimate. In cases where the employer's estimate is not reasonable, a penalty is imposed on the employer.

In order to approximate the premiums charged to an employer who purchases health insurance for employees, the cost of providing coverage under a self-insured plan is defined as the liability incurred for benefit payments under the plan plus all other costs, including administrative costs, incurred with respect to the plan. For purposes of assisting employers of self-insured plans in estimating the cost of providing coverage, S. 640 allows the employer to assume that his administrative and other costs equal 7 percent of the liability he incurs for benefit payments under the plan. In addition, employers whose premiums are fixed in advance but fluctuate from year to year based on prior experience under the plan are allowed to use an average cost of coverage based on the employee's premiums for the preceding three years (adjusted to reflect changes in the cost of health insurance).

Multiemployer plans present an unusual situation, since the multiemployer plan rather than the employer actually provides the insurance coverage to the employee. This presents no problem in determining the employee's income from excess employer contributions. The multiemployer plan is required to determine the amount of excess employer contributions in the same manner as if it were an employer.

That is, excess employer contributions will equal the excess of the cost of the health care coverage actually provided to the employee under the plan, reduced by any employee contributions, over the applicable monthly limit. This amount is to be reported by the multiemployer plan to the employee and is to be used by the employee in determining his actual income and social security tax liability for the year.

However, multiemployer plans do present technical difficulties for employers with respect to withholding and payroll taxes. Under a multiemployer plan, employees work for a number of different employers and each employer contributes a fixed amount to the plan to provide health care coverage for the employees. Contributions to the plan may be based on hours worked, pieces of work completed, weight of material moved, or some other measure of work done by the employees. The amount of contributions to the plan with repect to an individual employee bears no specific relationship to the employee's health care coverage under the plan. Furthermore, each employer has no knowledge of the coverage a particular employee has or the amount of contributions made with respect to the employee by other employers. In view of this lack of knowledge, it is not possible for an employer to determine the actual amount of excess employer contributions with respect to any individual employee. However, the employer's withholding and payroll tax obligations are based on the amount of the employee's income.

To resolve this technical problem, S. 640 provides a special rule for determining the amount of excess employer contributions for purposes of an employer's withholding and payroll tax obligations. Solely for these purposes, employers will treat a fraction of each contribution to the multiemployer plan as an exess employer contribution. This fraction, which will be determined by the multiemployer plan, is equal to that fraction of the average cost of coverage of all employees under the plan (reduced by the amount of any employee contributions) that exceeds the average of the monthly limits for family and individual coverage, weighted to reflect the relative amounts of family and individual coverage provided under the plan.

As representatives of the Department of Health and Human Services will describe in more detail, the Administration believes S. 640 will be a significant step toward controlling health care costs. For this reason, the Administration strongly urges rapid and favorable consideration of S. 640.

In connection with this proposal, the Administration believes that current proposals to provide health insurance for the unemployed should be financed by a reduction in the proposed limit on tax-free employer contributions to health plans for employees. For example, reducing the $175/$70 limit to $169/$68 would raise $300-400 million in additional revenue that could be used for health insurance for the unemployed.

TAX TREATMENT OF FRINGE BENEFITS

Existing law relating to the taxation of fringe benefits can be divided into two parts. One part of the law deals with specific fringe benefits that Congress has determined should not be subject to taxation. Generally the reasons for excluding from income each of these specific fringe benefits—referred to as statutory fringe benefits—is to promote nontax social policies. Examples of statutory fringe benefits that promote such policies include employee contributions for pension plans, group term life insurance, health care plans, medical care reimbursements, educational assistance programs, and dependent care assistance programs.

Statutory fringe benefits promote nontax social policy by providing a Federal tax subsidy when the specified fringe benefit is substituted for taxable compensation. An employee receiving a statutory fringe benefit is allowed to retain the full value of that benefit, rather than paying a percentage of that value to the Federal government as income and social security taxes. In effect, the Federal government is paying a portion of the employee's wages in order to encourage the employer to provide certain types of benefits to the employee. In addition, the employee's costs of compensating the employee are reduced by the amount of unemployment taxes and the employer's share of social security taxes that would have been imposed on cash wages.

The second part of current law on the tax treatment of fringe benefits relates to those fringe benefits that are not specifically addressed by statutory provisions. The taxability of these nonstatutory fringe benefits is currently governed by the general definition of gross income in section 61 of the Internal Revenue Code. Despite the fact that both Treasury regulations and numerous court decisions treat compensation paid in a form other than cash as includible in income under section 61, there is a public perception that a number of in-kind benefits received from an employer are not income and not taxable. It has not been possible to correct this erroneous perception because of the moratorium Congress has imposed on the issuance of Treasury regulations and rulings in this area. As a result, nonstatutory fringe benefits of substantial value are being excluded from income by employees.

Nonstatutory fringe benefits

The issue of the proper tax treatment of nonstatutory fringe benefits has been a matter of great concern to the Treasury Department for many years. A "fringe benefit" may be defined generally as any personal benefit, other than cash paid as wages, which is furnished by an employer to an employee because of the employment relationship. For a variety of reasons, a large segment of the public believes that a wide variety of nonstatutory fringe benefits do not constitute income and are not taxable. The result of this perception is that employers and employees are arranging compensation packages providing for more and more compensation to be paid as nonstatutory fringe benefits in the mistaken belief that these benefits are not taxable. This erroneous treatment of certain nonstatutory fringe benefits places employers who pay cash wages at a disadvantage, erodes the tax base, encourages uneconomic and complicated transactions, and reduces public confidence in the fairness of the tax system. For these reasons, we believe it is extremely important that Congress address the question of the proper tax treatment of nonstatutory fringe benefits.

The Internal Revenue Code includes all income from whatever source derived, including compensation for services, in gross income. Treasury regulations specifically include in income compensation paid other than in cash, stating that if services are paid for in property or services, the fair market value of the property or services taken in payment must be included in income as compensation. Unfortunately, despite these clear statements of principle, the administration of the tax laws with respect to nonstatutory fringe benefits has required the drawing of some very fine distinctions. One such distinction is that between working conditions and compensation. An employee often receives a personal benefit from working conditions that an employer provides solely to facilitate the execution of the employee's duties. Technically the personal benefit obtained by the employee from working conditions might be considered part of the compensation received for his employment and thus includible in income. However, in administering the tax laws, the Internal Revenue Service has consistently taken the position that working conditions are not part of an employee's compensation and are not income to the employee. Distinctions between working conditions and compensation are not always clear. For example, prior to the enactment of section 119 which established certain objective criteria for determining which employer-provided meals and lodging are excludible from income, difficult questions were often raised about whether meals and lodging provided to employees were intended for the convenience of the employer, and therefore qualified as working conditions, or were intended as compensation.

Similarly, it is often difficult to determine whether a benefit provided by an employer to an employee is a gift or compensation. In 1921, the IRS announced that free personal railroad passes issued to employees were gifts rather than compensation. Based on this prior IRS position, many believe that free passes for airline travel are also gifts, and therefore nontaxable, despite the substantial benefit conferred on the employee by such passes.

The result of the existence of administrative exceptions to the statutory rule has been confusion about the taxability of a variety of in-kind benefits provided as compensation. Because of this confusion, the value of many nonstatutory fringe benefits is often being treated by employers and employees as not includible in the employee's income. When compensation is paid in fringe benefits, but the value of the fringe benefits is not included in income, employees with equal economic incomes are taxed unequally, depending on the relative amounts of cash and in-kind compensation each receives. In addition to causing losses of Federal income and social security revenues, this inequitable treatment of cash and in-kind compensation reduces public confidence in the fairness of the tax system.

During the early years of our income tax system, the use of fringe benefits to compensate employees was relatively rare and the marginal tax rates were quite low. Therefore, the adverse effects of employees' failing to include the value of fringe benefits in income was limited. However, as inflation has pushed many taxpayers into higher tax brackets, the increase in the value of nontaxable compensation, combined with the erroneous perception that certain nonstatutory fringe benefits are nontaxable, has caused increased use of noncash compensation.

In the early 1970's the IRS became concerned by the incresing use of fringe benefits by employers. A review of the matter led to the conclusion that the administratively drawn lines between taxable and nontaxable fringe benefits needed to be clarified. In 1975, the Treasury Department circulated a discussion draft of regulations that would have provided specific rules for determining when a nonstatutory fringe benefit was taxable. This discussion draft met with substantial opposition from the public. The discussion draft was withdrawn and, after much debate, Congress in October, 1978, imposed a moratorium on the issuance of new rulings or regulations relating to fringe benefits. This moratorium has been extended several times, and is currently scheduled to expire on December 31, 1983.

The effect of the moratorium has been the perpetuation of inconsistencies in the administration of the tax laws relating to nonstatutory fringe benefits. In the absence of uniform national guidelines, the tax treatment of particular fringe benefits is being determined by individual IRS agents at the local level. This practice results in inconsistent treatment from district to district and even from agent to agent. The inability of the Treasury Department to provide IRS agents and the public with a clear statement of the proper treatment of nonstatutory fringe benefits has left employers and employees confused at best. In addition, the moratorium has substantially strengthened the public perception that nonstatutory fringe benefits are not taxable under current law. Understandably, this perception results in very poor voluntary compliance in reporting by both employers and employees of the value of fringe benefits for income tax purposes. Voluntary compliance with reporting requirements is a key element of our tax system. Without it, the administrative costs of collection would be substantially increased.

In 1981, the prior administration, in response to the request of the Chairman of the House Ways and Means Committee, released another draft of regulations relating to nonstatutory fringe benefits. The 1981 draft again met with public opposition and an extension of the Congressional moratorium.

In view of this recent history, we have concluded that it is not possible for the Treasury Department to clarify the tax status of nonstatutory fringe benefits without legislative action. Legislative action is needed to provide clarification because there are a number of fringe benefits that have been assumed by the public to be nontaxable for a long period of time but which cannot be excluded from gross income by regulation. The primary examples of such fringe benefits are airline passes, tuition reimbursements, and merchandise discounts (other than discounts having a de minimis value). Because the perception of nontaxability of these benefits has been allowed to persist for a long period of time, resistance to clarification that such benefits are includible in income under existing law is substantial. Since exclusions of these benefits from income would be inconsistent with existing statutory provisions, it will not be possible for us to develop a regulatory fringe benefit proposal that will not generate substantial controversy. As the repeated extension of the moratorium indicates, Congress considers such controversy to be unacceptable. Therefore, we would like to discuss today some alternatives that Congress might consider in deciding how to clarify the tax treatment of fringe benefits.

One approach that Congress might take to resolving the issue of the taxability of fringe benefits would be to provide statutory exclusions for those nonstatutory fringe benefits which the public has considered nontaxable for a substantial period of time. While this approach avoids controversy, it would be a substantial departure from the prior Congressional practice of providing statutory exclusions for certain fringe benefits to promote desirable social policies. We see no desirable social policy that would be promoted by excluding from income the value of fringe benefits such as airline passes, tuition remission, or store discounts. Exclusion of such benefits would simple grant preferred tax treatment to employees in certain industries and professions.

Furthermore, we are concerned that any list of exclusions from income of current nonstatutory fringe benefits would become so comprehensive that it would not only permit but encourage greater use of fringe benefits to provide tax-free compensation. The result of enacting such board legislation would be aggravation of the existing problems of inequitable treatment of taxpayers with equivalent economic income, loss of Federal revenue, and erosion of public confidence in the tax system. Legislation that explicitly excluded some existing nonstatutory fringe benefits might be preferable to an extension of the present moratorium on fringe benefits if the list of excluded benefits were narrowly drawn, or possibly if a low dollar limit were placed on the total amount that could be excluded under this new class of statutorily-sanctioned fringe benefits.

As alternatives to totally excluding certain nonstatutory fringe benefits from taxation altogether, we suggest that consideration might be given to addressing two elements of past fringe benefit proposals that have caused concern—the difficulties of determining fair market value and the perceived hardship imposed on employees when they must obtain cash to pay taxes on the value of in-kind benefits that cannot be converted into cash.

It is true that there are many cases in which the fair market value of a fringe benefit is difficult to determine. We believe that this difficulty justifies the development of either administrative or statutory guidelines for approximating the fair market value of fringe benefits or alternative methods of assigning a value to fringe benefits. In valuing a fringe benefit, all facts and circumstances relating to the employee's receipt of the benefit must be taken into account. For example, merchandise that is normally sold at retail with a warranty will not have a fair market value equal to the retail price when purchased by the employee at a discount and without a warranty. As a practical matter, it might be appropriate to provide that a warranty is assumed to account for a specified percentage of the retail price of an item. Similarly, a presumption could be established that imposing a standby condition on transportation would reduce the retail price of the transportation by a specified percentage. We believe the problems of valuation could be substantially reduced by such rules.

Commentators have suggested that the employer's allocated cost could be used to value fringe benefits. We are not convinced that the determination of an employer's allocated cost is substantially less difficult than the determination of fair market value in many cases. However, further consideration should be given to whether valuing fringe benefits at allocated cost plus an assumed fair rate of return on such cost would be more practical than valuing fringe benefits at fair market value.

Valuation problems could be reduced by taxing fringe benefits at the employer level. A tax at the employer level would avoid the need to allocate the value of fringe benefits to individual employees. For example, an employer that provides a free cafeteria for employees may have difficulty determining the value of the meals eaten by each employee. However, it would not be difficult to determine the aggregate value of all meals served in the cafeteria. Similarly, an employer may know the total amount of discounts to individual employees.

Taxation at the employer level would also address the problem of imposing a substantial tax liability on employees who cannot convert their in-kind compensation into cash. Taxation at the employer level could be accomplished either by disallowing business deductions related to the fringe benefits or by imposing an excise tax on the employer on the value of all nonstatutory fringe benefits provided to employees. Either of these proposals could be combined with the allocated cost plus fair return method of valuation. In the case of disallowance of deductions, the employer's deduction for wages could then be reduced by an amount equal to the aggregate allocated cost of the fringe benefits provided to employees plus a fair rate of return on that cost.

Addressing the fringe benefit problem at the employer level would be fair. Such a solution simply says that if the employer wishes to provide compensation designed to avoid tax, he cannot have it both ways. He cannot design compensation that permits employees to pay no tax while still retaining the full tax benefit of deductions for himself. The system cannot afford growth of this inconsistent treatment by employers.

These proposals are not without their own problems. A significant problem of substituting disallowance of the employer's deduction for inclusion in the employee's income is that nontaxable entities would not be affected by such a provision. In addition, denial of the business expense deduction has the disadvantage of resulting in inequities between taxable employers depending on their marginal rate of tax, and of having the tax that is imposed with respect to the fringe benefit bear little, if any, relationship to the tax that would have been imposed on the employee.

Some of the disadvantages of denying deductions for business expenses might be avoided by imposing an excise tax on the value of fringe benefits provided by employers. Such an excise tax could be set at an average marginal rate where benefits in question are provided to employees on a nondiscriminatory basis, but at a higher rate where the benefits are provided only to highly compensated or key employees. Such an excise tax would affect all employers equally, without regard to their tax status or the amount of their taxable income.

In summary, we believe that the moratorium on fringe benefit regulations is having serious adverse effects on revenues and the tax system generally. However, we believe that political considerations make a regulatory solution to the problem impossible. Therefore, we believe that a comprehensive legislative approach to nonstatutory fringe benefits should be considered in place of a further extension of the moratorium. We would be happy to work with you to develop an acceptable legislative proposal.

Statutory fringe benefits

The area of statutory fringe benefits presents for the Treasury Department many of the same tax policy concerns which we have outlined above in our discussion of nonstatutory fringes. Statutory provisions currently exclude from an employee's income employer payments for up to $50,000 of group term life insurance, up to 5,000 of death benefits, health plans, medical expenses, rental or parsonages, certain benefits for members of the Armed Services, meals and lodging furnished for the convenience of the employer, group legal services plans, van pools, educational assistance programs, and dependent care assistance programs.

As these different exclusions proliferate in type, the programs under which they are offered are growing in both number and popularity. While we recognize that Congress in establishing the various statutory fringes has believed that a nontax social policy justified each new exclusion, we doubt that Congress envisaged a system under which a significant portion of each employee's compensation is provided in nontaxable fringe benefits. The groundwork for just such a system is being rapidly established, however, through use of the cafeteria plan rules. We appreciate the efforts of this Committee to focus on the cafeteria plan rules as part of its examination of the entire fringe benefit problem.

A cafeteria plan is an arrangement by which an employer can enable its employees to choose among cash or a variety of statutory and nonstatutory fringe benefits. These "flexible benefit" plans were made possible by Code section 125, enacted by the Revenue Act of 1978. This section permits an employee to select a nontaxable benefit under a plan offering a variety of benefits without being subject to taxation on any nontaxable benefits selected. In the absence of section 125, under the doctrine of constructive receipt, the existence of an option to receive cash (or another taxable benefit) would result in taxation to the employee.

In order to qualify for the special tax treatment provided by section 125, a cafeteria plan must not discriminate as to employees' eligibility to participate and must not discriminate in favor of highly-compensated participants as to nontaxable fringe benefits (or employer contributions to such benefits). These nondiscrimination rules were designed to prevent use of cafeteria plans as means by which highly compensated individuals can avoid or defer tax on a disproportionately high share of their compensation as compared to less highly compensated individuals.

Prior to the establishment of cafeteria plans, there was a practical limitation on the extent to which employers could provide compensation to employees in the form of nontaxable fringe benefits. Economically, any individual empolyee would prefer to receive more compensation in the form of nontaxable fringe benefits only if the employee needed or would use the additional fringe benefit as much as the cash payment that otherwise would be paid, less the tax that would be imposed on that cash compensation. The need for additional fringe benefits would differ from employee. As a consequence, the provision of additional fringe benefits would be sought by some employees and opposed by others. In the past, employees as a group have reached a mutually satisfactory accommodation where the level of fringe benefits offered by each employer is acceptable to the employee group as a whole.

The level of benefits at which any group of employees develops conflicting interests will depend on the type of benefit being considered and the particular circumstances of the employees. For example, all employees may desire medical insurance protection up to a certain level, However, employees without dependents may want to limit the level of employer-provided health insurance to coverage for a single employee. Collectively, these employees will resist reducing their general level of cash compensation in order to provide more extensive insurance protection that would benefit only employees with dependents.

The establishment of cafeteria plans eliminates "employee jealously" as a constraint upon the use of fringe benefits as a principal means of compensation. Under a properly designed cafeteria plan, an employee will never bear any portion of the economic cost of the fringe benefits enjoyed by other employees. Again looking to the example of medical insurance, an employee will not care if another employee receives tax-free comprehensive health insurance coverage for an entire family so long as he or she can receive either cash or an equivalent amount of compensation in the form of a desired tax-free fringe benefit.

The types of tax-free benefits which are typically made available under cafeteria plans include disability benefits, accident and health insurance, group term life insurance, dependent care assistance, qualified group legal services, and a cash or deferred "section 401(k)" profit-sharing plan. The most common nonstatutory fringe benefits included in cafeteria plans are free parking and extra vacation days. However, as these plans become more widespread, the list of other available nonstatutory benefits could be expanded considerably. The ability to choose among these different fringe benefits which is faciliated by cafeteria plans, combined with the cash option feature, is virtually certain to expand significantly the level at which statutory fringe benefits are provide in lieu of taxable compensation.

The Treasury Department is concerned that there is a considerable potential for abuse of the cafeteria plan concept as a result of the availability of cash or taxable fringe benefits as a permissible plan distribution. Despite considerable efforts during the process of drafting the cafeteria plan regulations, we have found it particularly difficult to prevent this taxable benefit option from creating problems with respect to both salary reduction and discriminatory utilization of plan benefits.

It is unclear under Code section 125 or its legislative history whether Congress intended to permit widespread funding of cafeteria plans through the reduction of each participating employee's salary. The Treasury Department examined at length the difficulties of differentiating between a cash option and a salary reduction option during the process of drafting the proposed regulations under section 401(k). In the case of those qualified cash-or-deferred retirement arrangements, we proposed to permit the plans to be funded by salary reduction. By contrast, in the case of cafeteria plans, the availability of plan funding through salary reduction would permit employees to substitute for taxable wages unlimited amounts of fringe benefits which are tax-free by statute or are perceived to be tax-free under the moratorium on dealing with nonstatutory fringe benefits. Depending upon the timing of the salary reduction election, each participant in a cafeteria plan could select the maximum possible nontaxable benefit in light of his expenses for any taxable year, thereby simultaneously maximizing the government's revenue loss with these flexible benefit programs.

An example will illustrate the problems which would be created if cafeteria plans could be funded by salary reduction. Consider a cafeteria plan which offers company employees a choice between self-insured medical reimbursement benefits, dependent care assistance, life insurance benefits, "free" parking, or cash. The plan provides for a thirty percent reduction in the salaries of all participating employees. Under the terms of the plan, an employee can elect on a month-to-month basis the distribution of amounts paid out of the plan. Assume that employee A, who earns $50,000 per year, requests allocation of $15,000 between medical reimbursement and dependent care assistance, while Employee B, who also earns $50,000 per year, withdraws all his "contribution" in cash. Employees C and D, who earn $10,000 per year, each request $1,000 in medical reimbursement, a $500 contribution towards life insurance, and $1,500 in cash. Only the cash withdrawals are subject to tax. Thus in this example Employees A, C, and D save income and social security taxes on a total of $18,000, while the employer saves social security and unemployment taxes on the same amount. This program appears to be discriminatory in that tax-free benefits totalling $15,000 have been withdrawn by one of the highest-paid exployees, while each of the lower-paid employees received only $1,500 in tax-free benefits. However, under the rules of section 125, this plan is not discriminatory. The plan benefits have been made available to all employees, and the nontaxable benefits withdrawn from the plan by the two highly-paid participants do not, as an average percentage of salary, exceed the nontaxable benefits withdrawn by the less highly compensated. It is extremely unlikely, however, that this plan could have been established were it not for the availability of the cash option. Employees B, C and D would have opposed creation of a generous plan of tax-free benefits which they would not expect to utilize fully in lieu of a portion of their cash compensation.

The addition of nonstatutory fringe benefits to cafeteria plans has increased the already substantial confusion about the taxability of such benefits. Many employees assume that any benefit other than cash received through a cafeteria plan is nontaxable. As described above, there is a need for legislative clarification of the tax treatment of nonstatutory fringe benefits. Until such clarification is made, we believe it is undesirable to aggravate the problems in the nonstatutory fringe benefit area by allowing such benefits to be included in cafeteria plans.

Absent legislative action, cafeteria plans will be used to an increasing extent to expand both the level and type of fringe benefits that will be provided to employees. To avoid both the revenue loss and potential discrimination caused by the taxable benefit option, the Treasury Department recommends that Congress limit both the types and amount of benefits available under cafeteria plans. We believe that the types of fringe benefits which can be offered under such plans should be restricted to cash, in a limited dollar amount, and to those statutory fringe benefits which are currently available under such plans. To the extent that salary reduction is perceived to be the practical equivalent of a cash option, the maximum amount of salary reduction by an employee participant in a cafeteria plan would be subject to the same annual dollar limitation applicable to cash payouts from the plan.

This concludes my prepared remarks. I would be happy to answer your questions.

The CHAIRMAN. As I understand, Mr. Chapoton, you have a commitment at the White House at—what?—10:45. So we are going to try to start with Dr. Rubin.

Do you have to be there, too?

Dr. RUBIN. No, sir.

The CHAIRMAN. Lucked out. OK. [Laughter.]

Dr. RUBIN. I would like to go, if you could arrange it.

The CHAIRMAN. Well, I can get you a tour, but I don't know how to get you to see anyone. [Laughter.]

So if it is all right with Dr. Rubin, let me yield to Senator Packwood under the early bird rule, and we will address a few questions to you, Mr. Chapoton. Then we will excuse you, but I assume you may need to come back at a later time.

Mr. CHAPOTON. I will be happy to come back, Senator.

The CHAIRMAN. Bob.

Senator PACKWOOD. Buck, I don't quite understand what you have written about the health cap in your testimony—on the bottom of page 3 or 4, where you are talking about plans that do not have a prospective payment but instead a retroactive payment based upon costs.

As I read your paragraph, it looks like you are saying that if retroactive costs happen to exceed your cap, they would still not be charged as income to the employee. Is that correct?

Mr. CHAPOTON. That is correct. The retroactive change would have no effect on the income to the employee.

Senator PACKWOOD. So would it be possible in your estimation for the employer to get around what you are trying to achieve, then—the employer and the union—by simply creating a plan that paid benefits retroactively?

Mr. CHAPOTON. The benefits would have to be specified in the plan, and there would have to be a reasonable estimate of those benefits. And there is a penalty mechanism if the estimate is not a good faith, reasonable estimate.

Senator PACKWOOD. All right. I didn't see that here.

Second, can you tell me how you have estimated the revenue to the Treasury that will be gained if the cap is enacted?

Mr. CHAPOTON. Senator Packwood, there is an assumption that in the long run there will be a shift to more cash compensation and less medical insurance.

Initially, though, we just look at the plans that would be over the cap and that are projected to be over the cap in 1984 and beyond. In other words, there is an estimate the same plans will be over the cap, in which case obviously you are picking up taxable income.

Senator PACKWOOD. So, Treasury in this case has followed its normal revenue projection on a static basis. They just looked at the benefit plans that are over the cap and assumed they would be kept at that level, or lowered down to the cap, or one of the two. I'm not quite sure, exactly, what assumptions you have ordered.

Mr. CHAPOTON. Well, they will tend to reduce the benefits under the cap; but I think we would assume that would be replaced possibly in part with other tax-free benefits, and that is built into the revenue estimates as well. In other words, the compensation alternative might be in part another tax-free benefit not subject to a cap, or at least under the cap if that benefit has its own cap, and in part taxable compensation.

Senator PACKWOOD. Would you send to me a letter very specifically laying out your assumptions? Because I don't think you are going to collect as much money as you think, and I would like to know what your assumptions are.

Mr. CHAPOTON. Yes; I would be happy to.

[The letter follows:]

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

ASSISTANT SECRETARY

AUG 4 1983

Dear Senator Packwood:

This is in response to your request for a description of the methodology and assumptions used to estimate the revenue gain from the health insurance tax cap proposal.

The basic tool used for the estimate is the Office of Tax Analysis Individual Income Tax Simulation Model (Tax Model). The model is comprised of a stratified random sample of about 80,000 individual income tax returns and complex computer software designed to replicate the individual income tax. This model is used to estimate the revenue effect of nearly all individual income tax proposals.

The data on the Tax Model is limited to information reported on tax returns. Thus, proposals that alter the definition of income such as the health insurance proposal or allow special deductions or credits often require that nontax data sources be used. The Department of Health and Human Services (HHS) projections of total employer contributions to health insurance and the National Medical Care Expenditure Survey (NMCES) are the two main sources used to supplement the data on the Tax Model.

HHS provided projections of total employer contributions to health insurance. These projections are consistent with the Administration's April economic forecast and incorporate actual 1981 data on employer contributions.

The NMCES data base is used to impute the employer contributions to selected tax returns on the Tax Model. NMCES is a national survey of 14,000 households conducted in 1977-1978. The survey provides data on the amount and distribution of employer contributions by size of contribution, income of the employee and marital status. The NMCES data base has been widely referenced and was used as the basis for the 1982 Congressional Budget Office publication, Containing Medical Care Costs Through Market Forces.

The NMCES data is for 1977, thus a number of adjustments were necessary before the information could be used to impute amounts to tax returns. First, the size distribution of employer contributions was extrapolated using the growth rate in average employer contributions. It was assumed that the distribution of the size of employer contributions about the mean remained constant from 1977 to 1982. Second, income levels in 1977 were assumed to grow by the average growth in family income from 1977 to 1982.

Returns on the Tax Model were then classified by income level and marital status. Within each income class and marital status returns were randomly selected to have employer contribution of a given level made on their behalf. The selection process maintained the distributions by income class, by marital status, and by size of employer contributions that were reported in the NMCES data.

At this point then, each worker was identified as to the existence or nonexistence of employer contributions and each worker was imputed a contribution amount. The Tax Model software was then amended to allow for the taxation (income and social security tax) of employer contributions.

Employees with employer contributions above the cap are faced with three options: (1) maintain the same level of health insurance and pay tax on the excess contributions; (2) reduce their health insurance and substitute taxable wages, or (3) reduce their health insurance and substitute other forms of nontaxable compensation. The revenue gain is identical under the first two options, but there is no revenue gain to the extent that the employee elects the third option. Obviously, determining the amount of excess contributions converted to other forms of nontaxable compensation is critical in calculating the revenue effect of the bill.

During the past five years about 11 percent of the increase in employee compensation was in the form of nontaxable fringe benefits including employer health insurance contributions. This percent is expected to increase to nearly 15 percent during the 1984-1988 period under the most recent economic forecast prepared by the Administration. For purposes of the revenue estimate, then we assumed that 15 percent of the excess contributions would be converted to other nontaxable forms of compensation and would, therefore, not yield any additional revenue. It is important to note that this assumption yields a conservative estimate of the revenue gain since the 15 percent calculation includes health insurance as a nontaxable benefit. Eliminating this nontaxable option, eliminates one of the largest and most broadly utilized fringe benefits.

A final adjustment was made to account for the provision that legally binding contracts be exempt from the tax cap for a period not to exceed two years.

I hope that this information is helpful. Please feel free to contact me if you have any further questions.

Sincerely,

/s/ John E. Chapoton

John E. Chapoton
Assistant Secretary
(Tax Policy)

The Honorable
Bob Packwood
United States Senate
Washington, D. C. 20510

Senator **Packwood**. Next, there is a statement in your testimony that the employers really don't care how much health insurance they provide because in essence it's the same as wages for them; it's a business deduction for them and so they don't bargain very hard for any particular level.

In my experience, although it has been 20 years ago, when I was bargaining labor contracts——

Mr. **Chapoton**. Did you say the employers, or the employees?

Senator **Packwood**. The employer. For the employer a business deduction is a business deduction. For the employee, and indeed for the union business agent, it makes a big difference.

But all I can tell you is that in my experience with bargaining, what you are saying was not true of the employer's position. They bargained hard against dramatic increases—this is 20 years ago, and I don't know why it should have changed—in health costs, because they saw them as a rapidly escalating expense which they had no control over. If they promised to pay you so much for 20 days of hospital stay, and that went from $50 a day to $500 a day, they felt obligated to pay the costs. So they bargained hard against increasing benefits.

Mr. **Chapoton**. I would think that is certainly the case. We don't mean to imply that would not be the case. But vis-a-vis cash compensation, they can provide the same level of compensation cheaper if it is nontaxable to the employee.

Senator **Packwood**. Your dramatic objection to the cafeteria plans is at least that it removes the common denominator incentive not to have excessive benefits. Any number of employees may not have any use for any particular benefits.

Mr. **Chapoton**. That's the bottom line. Yes, Senator.

Senator **Packwood**. And if they can all have the choice of half a dozen, the 25-year-old widow with two children age 3 and 2 may choose day care as a very high benefit in her estimation, and a 50-year-old employee with no children is not going to choose that at all, and they are all going to find some way to reduce their taxable income to the lowest possible denominator by choosing different benefits, and you have lost the internal rigor of bargaining for a uniform benefit.

Mr. **Chapoton**. Well, as long as they are all confined to choosing tax-free benefits out of a specific list, I think the problem is low.

Senator **Packwood**. Your problem is the cash option.

Mr. **Chapoton**. The cash option. Yes, sir.

Senator **Packwood**. Is the administration going to have any position on the statutory fringe benefits that now exist? Any position on limiting those other fringe benefits?

Mr. **Chapoton**. No, sir. We have not made a proposal, and I know of no reason we would be taking a position on that at any time this year.

Senator **Packwood**. The reason I ask that, every now and then the ghosts of Stanley Surrey appear before this committee and want to tax all fringe benefits, because they feel the only purpose of the Tax Code is to collect money, not to provide social benefits.

I have said this to you, and I would say it to the administration: I think the one reason we do not have any significant demand for national health insurance in this country among those who are employed is because their employers are paying for their benefits, by and large. And we will never go to the situation we have in Great Britain so long as that system exists, and I hate to see us nibble away at it for fear you are going to have the demand that the Federal Government take over and provide the benefits that would otherwise be lost. And I hope the administration is considering that downside.

Mr. CHAPOTON. I think that question has been discussed in consideration of this proposal, which is basically cost containment.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Yes. Mr. Chairman, I do have a statement I would like be made a part of the record.

On that latter point, I guess I don't know what the administration's position is, but my view of the situation is that we already have national health insurance in this country, and we have it for 68 million out of 225 million people. And that's one of the issues we are trying to address here—how do we extend something in the nature of comparable benefits to the rest of this population so that they can afford it out of a health care system whose costs are largely being driven up by the national health insurance that exists in the employer-employee sector.

If you look through the kinds of coverage that are provided, you've got something pretty close to Britain—except that you can get into the doctor a whole heck of a lot faster here, you can get to the psychiatrist a whole heck of a lot faster, you can get to the dentist, you can go get your eyeglasses almost like that in America, and it doesn't cost you anything if you are in the right employment setting.

Now, none of us who support your position are arguing for national health insurance, in the sense that everybody ought to be covered for everything on an equal basis; but I would suggest to my colleagues that one of the things we are trying to do is wrestle with some equity in this system.

But Buck, let me ask you a question that relates to the cafeteria plan situation. I am not clear, because we did that section 125, as you indicated, back in 1978, and all of us who have been dealing in one way or another with the fringe benefits have been waiting for regulations.

I have a letter signed by you in December of last year pointing out some of the problems. And I am not quite clear whether or not your advice to us is that we wrestle with some of these problems that you face, or whether you do intend to address some of those in the form of regulation.

Mr. CHAPOTON. We intend to publish regulations under the existing statutory provisions. What I am saying is, we think the existing statutory provision causes concerns that Congress didn't foresee in 1978.

It has taken too long to issue the regulations. There have been tremendous problems. In connection with this testimony I reviewed it again. We are moving forward with a set of regulations on it. To be quite candid, the draft that is now prepared is not adequate, but these regulations have been given the highest priority. But the statutory correction that I am talking about is not holding up the regulations.

Senator DURENBERGER. And what does "high priority" currently mean? 1983?

Mr. CHAPOTON. No, they would definitely be issued this year. I would like to say—I think I could say by the end of the summer. I'm afraid I couldn't say much before then.

Senator DURENBERGER. I suggest that because, while I support in a general sense the administration's position on the bill that the chairman of this committee introduced, I'm certainly wide open and I hope a lot of us on this committee are open to finding better ways to accomplish some of the health policy objectives. And if we knew where you were headed with regard to choice in the cafeteria plan system, it would be very helpful to us.

Mr. CHAPOTON. I can see that, and I think that is a valid comment. As you well know, the important regulation projects always seem to get delayed as we go through the system. We are trying to address this, but it still needs a lot more work.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Senator Bentsen.

Senator BENTSEN. Mr. Chairman, I understand the Secretary has an appointment at the White House, and I will not pose any questions at this time because I think the White House does need his advice, and I would urge him to get on down there. [Laughter.]

The CHAIRMAN. Well, we appreciate that. He gives good advice, too.

Senator BENTSEN. Most of the time.

The CHAIRMAN. Could I just say as you leave—unless Senator Long has questions.

Senator LONG. No questions.

The CHAIRMAN. And he is available to return.

You know, we have gone from the numbers game to the real game now, and we are going to be faced with a budget resolution on the Senate floor in the next week. They have been playing around with these numbers now for 6 months. I have taken a look at those numbers, and if in fact that budget resolution is adopted, 88 percent of the impact comes through this committee—88 percent. I don't know what happened to the other 12, but it slipped away.

So now it is a question of whether they are going to transfer the numbers game to the real game. And if in fact that happens, it is going to be our responsibility to raise $73 billion in taxes. In fact, we are reconciled to do that if the budget resolution passes, in addition to some minor savings in medicare, which to me should be much greater.

But I know the President has indicated he is opposed to taxes, at least these taxes.

Mr. CHAPOTON. That is correct. He is certainly opposed to these taxes in 1984 and 1985.

The CHAIRMAN. But he wasn't opposed earlier this year to $56 billion in new taxes.

I don't mean to get you involved in that argument; I just suggest that these hearings are rather important. If in fact we adopt the budget resolution, then the games are over.

We are being told in the resolution to report back to the Senate by I think July 22 with a proposal from this committee that would raise $73 billion over the next 3 years. And I know that that would not include the third year or hopefully any change in indexing, so that leaves the rest of the Tax Code including fringe benefits to be addressed. And I understand the bill for that is about $175 billion over the next 5 years—that's for statutory. Nonstatutory is a couple of billion a year. So there is a lot of real money involved, and it makes our job rather difficult.

So I just suggest that generally to the administration.

I assume that if in fact the resolution is adopted by Congress and we are directed to raise the money, I assume the administration would—what would the administration do?

Mr. CHAPOTON. We will certainly work with the committee, Mr. Chairman. As you know, the President has stated unequivocally he does not think we should raise any taxes as we are coming out of the recovery. And he includes in that fiscal 1984 and 1985.

The CHAIRMAN. So if we made them effective in 1986 it would be all right?

Mr. CHAPOTON. Well, we certainly are supporting the standby tax that was part of the original President's budget.

The CHAIRMAN. Well, I don't mean to draw you into that argument, but we have to make a decision in the next few days. I am hoping that the Republicans on the committee can meet and the Democrats on the committee meet and see if we have 11 votes for anything. Otherwise, I don't see why we adopt a budget resolution when 88 percent of the money involved comes through this committee and there are not the votes for it.

That doesn't mean we stop—we may be able to do something on our own. I remain silent on the budget resolution, but we are looking at it.

Thank you.

Mr. CHAPOTON. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Rubin, we are happy to have you here today, and if you get any calls to go anywhere we will be happy to—— [Laughter.]

Buck has had more experience at being called away. [Laughter.]

I would say that your full statement will be made a part of the record. We are hoping that you might summarize it. We have 20-some witnesses today, and what we don't want to happen is for those on the tail-end to be literally excluded from testifying because the day is over or there are not many members around. So we are going to try to speed up the process on the front-end so we don't penalize the people on the back-end.

STATEMENT OF ROBERT RUBIN, M.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Dr. RUBIN. With your permission, I would like to summarize my statement and call your attention to some charts that will be here and also will be appended to the back of the statement.

In combination with the medicare and medicaid components of the President's health incentives reform program, the so-called tax cap—which I should quickly add is very different than the tax cap that is being proposed elsewhere on the Hill—will introduce incentives for efficiency into the health care system without inhibiting access to quality health services.

The administration's program is founded on the premise that reimbursement controls on physicians and hospitals cannot by themselves halt health care inflation. Instead, we must change the economic incentives facing all the key participants in the health care system, including the consumer.

The major threat to quality medical care in this country is a continuation of the trend of inordinate inflation in health care expenditures. Most of these expenditures in the private sector are financed by employers and encouraged by the tax system.

As you can see in the first chart, employer payments to health plans are projected to increase by $100 billion between 1983 and 1990. These payments have been nearly doubling every 5 years.

Under current law, as you have heard, an employer's contribution to an employee health plan is not included in the employee's taxable income.

The second chart shows how the tax cap would work. In essence, what we would do is to limit tax-free employer-paid health benefits to $175 a month per family and $70 a month for individuals, while excess employer-paid benefits would be treated as ordinary income for tax purposes. This program would be effective on the first of January 1984, with the exception of legally binding contracts which would have until January 1, 1986, to come into alinement.

We would index the tax cap as the rest of the Tax Code will be indexed, to the Consumer Price Index.

This tax change is expected to yield roughly $2.1 billion in tax revenues in fiscal 1984, and about $27 billion over the 5-year period from fiscal 1984 through fiscal 1988.

Since higher-paid workers are more likely to have rich employer-paid health plans and face higher marginal income tax rates, they are the primary beneficiaries of the existing tax preference. By the same token, high-income workers would be more likely to be affected by the tax cap.

The fourth chart shows that for taxpayers affected by the cap, the amount of new tax liability increases with income. The average tax increase for all taxpayers affected by the cap in 1984 would be approximately $228, or about $19 to $20 per month. The vast majority of taxpayers, however, would not have any new tax liability. Therefore, the average new tax liability for all taxpayers for 1984 would be only about $30, or a little more than $2 a month.

Senator BENTSEN. Let me understand that chart a little better, would you? Would you elaborate on that chart so we can see just what you were referring to?

Dr. RUBIN. The bars show that the average additional tax for taxpayers affected, by income class—so, for example, people making between $10,000 and $15,000 a year, based on their 1982 adjusted gross income, would have an additional tax liability of $153 per year. However, because very few taxpayers in the $10,000 to $15,000 class would be affected, the average tax liability for all people making that amount of money would be roughly $15 per year, or a little more than $1 per month.

The CHAIRMAN. What about in the upper brackets?

Dr. RUBIN. Well, as you can see, Senator, going up to between $100,000 and $200,000, those folks who are affected would have an increase tax liability of about $396 per year.

Senator PACKWOOD. Dr. Rubin let me ask you a question, then. You state that the primary beneficiaries of the existing tax structure are higher income workers, and that this is unfair. In 1978 I succeeded in adding a provision on self-insurance for health that you could not discriminate in the provision of benefits. And we now have several fringe benefits that have provisions that prohibit discrimination between well-paid and lower-paid employees. This would solve that problem for you if we simply added that clause to health insurance, wouldn't it?

In other words, you say all employees get the same benefits: it doesn't matter if they make $15,000 or $50,000.

Dr. RUBIN. Well, I think that was part of what Mr. Chapoton was addressing in some of his previous concerns vis-a-vis the cafeteria plan.

Senator PACKWOOD. His worry was more on the cash option and he didn't worry so much about the cafeteria plans. I am talking about saying that you cannot discriminate in the providing health benetits.

Dr. RUBIN. Well, there is no discrimination in the provision of benefits here within particular employer-based contributions. That is to say, employers have to offer the same benefits to all their employees.

Senator PACKWOOD. You don't have that provision in the law; you have for some other fringe benefit plans. But, that is the case, then your statement on page 3 of your testimony inaccurate—that the higher paid employees benefit more from the tax treatment of health benefits than low paid employees. If everybody gets the same payment for the same benefits, and they are tax-free, then it is of no greater importance to the lower-paid than to the higher paid employee, or vice versa.

Dr. RUBIN. Well, I think what we are talking about here is that people who have different employer-based plans because they are in different employment groups tend to have a different tax liability. On the average, employment groups with high average wages have more extensive health benefits than lower wage groups. So therefore, I think the statement and the numbers are indeed accurate. But I see that I suffer by not having my Texas tax lawyer sitting next to me here.

Senator PACKWOOD. Well, I won't pursue it because I think from a tax standpoint you are mistaken. You say, higher paid workers are more likely to have rich employer-paid health plans, which they indeed do, because there is not a nondiscriminatory provision. But that sole problem could be rectified by making health plans nondiscriminatory.

Dr. RUBIN. Discrimination within firms is not the sole reason for the correlation between wages and health benefits.

Senator PACKWOOD. But I won't pursue it at this stage.

Dr. RUBIN. The tax preference for employer-provided health insurance is based on the premise that our society should encourage adequate levels of health care and protection against the financial consequences of serious illness.

The administration accepts that premise; however, we believe that there should be a limit beyond which the choice between health benefits and wages is tax-neutral. Otherwise the tax exemption for health benefits will cause further health-expenditure inflation.

Now, it is not just the inflation rate in health expenditures that leads us to recommend these reforms. If the additional expenditures signal commensurate improvements in the health of the employed population, obviously these dollars would be well-spent. However, the facts suggest that this is not necessarily the case.

There are two links in the chain by which the tax treatment of employer-provided health benefits contributes to wasteful inflation in health care expenditures:

The first is that preferential tax treatment causes firms to provide more coverage and different types of coverage than they would in the absence of the tax preference.

Second, the expanded coverage with few internal controls on costs causes providers to deliver more services and more expensive services than they would if consumers had different insurance coverage.

These two links are well documented in a number of research studies.

It is an illusion to suppose that workers are protected against paying for these inflated expenditures by their insurance coverage. They certainly do pay for it in terms of foregone wages eaten up by higher health benefit payments.

Analysts who have examined the tax cap proposal in the administration, in the Congressional Budget Office, and in private research organizations all conclude that it would bring about a change in employer-paid health benefits and a lower rate of inflation in health expenditures than would be the case under current law.

Although it is difficult and imprecise to determine the exact magnitude and timing of these changes, the HHS Office of Planning and Evaluation estimates that in 1990 the tax cap will produce over $20 billion in savings in employment-based health expenditures, as illustrated in the next chart.

To achieve these savings, some employers, principally those who have very deep and very broad health benefits, will have to decide whether and in what manner to respond to the prospect of exceeding the tax cap.

One response would simply be to accept the new tax liability and add excess health benefits to employee income for the purposes of withholding and taxation. This is clearly not the ideal response from a health-policy perspective, but at least it does accomplish the goal of placing health benefits on an equal footing with the other forms of taxable compensation. Inflationary forms of health-care financing would no longer be completely tax sheltered.

A similar response would be to keep health plans intact, reducing the employer contribution so that the cap is not exceeded, and increasing the employee share commensurately.

A more interesting and perhaps constructive employer response would involve reforms in the way health benefits are structured and health plans are managed. And these strategies are outlined in chart 6.

A relatively simple method of reducing health care costs is to increase deductibles and/or coinsurance, keeping benefits and plan management the same. This is the so-called cost sharing approach. This strategy has been adopted by a number of firms seeking to reduce health care costs. Because patient cost sharing reduces utilization of health care services, the cost sharing strategy would reduce not only the firm's share of employee health care costs but also the rate of increase in total health care costs.

Some firms, for a variety of reasons, may prefer not to adopt this approach.

Another approach that they may choose is to redesign health benefits to bring about more cost-effective use of health services.

By expanding coverage for ambulatory services, surgical second opinions, and other programs, some employers claim to have saved money, even though this approach represents an increase in benefits.

Employers may also encourage the use of cost-effective providers to save money while maintaining coverage levels. Examples of this strategy, of course, are health maintenance organizations and so-called preferred-provider organizations.

Identification of efficient providers requires developing a data collection capability that enables employers to discriminate between appropriate and excessive utilization and prices. Private utilization review is a data-intensive activity that has great cost-savings potential.

In some parts of the country coalitions of employers have formed to, among other things, develop comprehensive data bases on provider pricing and treatment practices in their respective market areas.

A final approach that employers may take in responding to the tax cap is to become directly involved in the enhancement of employee health. Worksite health promotion and disease prevention programs have been alleged to save health benefit dollars and to reduce absenteeism and turnover as well.

It is a hopeful sign that private industry is currently experimenting with a variety of ways to hold down health care expenditures. Our tax cap is entirely consistent with this trend. The financial incentives embodied in the cap will encourage more employers to adopt cost-saving innovative practices. More employee cost sharing, more carefully selected plan benefits, and more aggressive plan management will combine to slow the rate of increase in health expenditures.

In conclusion I would like to emphasize the following points:

First, the current tax treatment of employer-paid health benefits is unfair, and this inequity is getting worse over time. It is unfair to the unemployed and to others who do not have this form of nontaxed income available to them. The current tax preference goes far beyond its original intent of encouraging protection against the financial consequences of serious illness. It is increasingly becoming a tax loophole for high-paid workers.

Second, current law contributes significantly to inflation in private health expenditures, most of which are financed by employers.

Available evidence establishes the chain through which the tax preference encourages excessive and inefficient insurance coverage which, in turn, fuels inflation in health expenditures. These rapidly rising health expenditures are doing little to improve our Nation's health.

Third, this problem is getting worse at an alarming rate. Current law projections indicate that employer-paid health expenditures will increase dramatically in the 1980's.

Our tax cap is a modest proposal. It does not prescribe a particular cost-containment technique but rather corrects the tax law's distorting effect on private activities in an important sector of our economy. It should be viewed as a catalyst to effective private health care cost containment and a useful complement to our efforts to improve the efficiency of medicare and medicaid.

Equally important, it would not adversely affect low-income people. Instead, it would help assure that all of our citizens—privately insured as well as medicare and medicaid beneficiaries—participate in our efforts to control health care costs.

I would be happy to answer any questions you may have.

[The prepared statement of Dr. Robert Rubin follows:]

STATEMENT OF ROBERT J. RUBIN, M.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Subcommittee: I am pleased to have the opportunity to discuss the Administration's proposal to limit the exclusion of employer-paid health insurance from employee taxable family income.

In combination with the Medicare and Medicaid components of the President's Health Incentives Reform Program, this "tax cap" proposal will introduce incentives for efficiency into the health care system, without inhibiting access to quality health services. The Administration's program is founded on the premise that reimbursement controls on physicians and hospitals cannot by themselves halt health care inflation. Instead, we must change the economic incentives facing all of the key participants in the health care system, including the individual consumer, the physician, the hospital, and the employer and union buying group health care coverage.

The major threat to quality medical care in the United States is a continuation of the trend of inordinate inflation in health expenditures. Most of the expenditures in the private sector are financed by employers and encouraged by the tax system. Employer payments into health plans are projected to rise from $50.5 billion in 1980 to $178.4 billion in 1990. Employers will divert employee compensation away from taxable wages in order to pay for these inflated health benefits.

In the remainder of my testimony, I will describe the Administration's proposal and the rationale for the tax cap. Before concluding, I will also describe how employers may introduce efficiencies into health plan design and management in response to the tax cap.

DESCRIPTION OF PROPOSAL

Under current law, an employer's contribution to an employee health plan is not included in the employee's taxable family income. The employer's contribution is, however, deductible as an "ordinary and necessary" business expense.

Beginning January 1, 1984, the Administration's proposal would limit this open-ended tax preference to $175 per month for family coverage and $70 per month for individual coverage. Employer contributions above these amounts would be included in the employee's taxable family income and would be subject to the employer's share of employment taxes.

Health plan contracts which are in effect on January 1, 1984, and which bind an employer to a specified contribution, would be allowed to reach their normal expiration dates without creating any new liability. However, this exemption will extend no later than January 31, 1986.

The $175/70 exclusion limit would be indexed to increase yearly in proportion to the Consumer Price Index (CPI). The CPI was chosen because it will be used to index the Federal income tax brackets beginning in 1985 and because our goal is to bring the health care inflation rate more into line with the general inflation rate.

Approximately 30 percent of employees receiving employer health plan contributions are projected to be in plans over the $175/70 cap in 1984. Because of the exclusion of binding contracts, however, only 22 percent of employees with an employer contribution will be affected by the tax cap in 1984.

The proposed tax cap will yield $2.1 billion in tax revenues in fiscal year 1984 and about $27 billion over the five-year period from fiscal year 1984 to fiscal year 1988. About 90 percent of the existing tax preference would be preserved in 1984.

Since higher-paid workers are more likely to have rich employer-paid health plans and face higher marginal income tax rates, they are the primary beneficiaries of the existing tax preference. By the same token, higher-income workers would be more likely to be affected by the tax cap.

On a related matter, we would note that our position on proposals to provide health insurance for the unemployed is that any such program should be funded through a reduction in a tax cap limit. A downward adjustment of the tax cap could produce substantial health benefits for the unemployed depending upon the amount of the reduction.

RATIONALE

The tax preference for employer-provided health insurance is based on the premium that society should encourage adequate levels of health care and protection against the financial consequences of serious illness. The Administration supports that premise. There should be a limit, however, beyond which the choice between health benefits and wages is tax neutral. Otherwise, the tax exemption for health benefits will cause further health expenditure inflation. Employers and employees should be free to negotiate health plans according to their preferences, but excessive employer-paid benefits should not be tax preferred. After some threshold, the tax law should neither encourage nor discourage added health benefits.

The United States currently spends over 10 percent of its gross national product (GNP) on health care, more than most other developed countries, and this percentage countinues to grow. Currently, 20 percent of all additions to GNP are for health care, and there is mounting evidence that the nation is not getting its money's worth.

It is not just the inflation rate in health expenditures that leads us to recommend reforms. If the additional expenditures signaled commensurate improvement in the health of the employed population or their families, these dollars would be well-spent.

There is considerable evidence showing wide variations in the health expenditures of different population groups that cannot be explained in terms of health care needs. Rather, it is extensive insurance, surpluses of doctors and hospitals, and different "styles" of medical care that seem to account for most of these variations. In short, is considerable inefficiency in the health care system than can be eliminated without endangering the health of our people?

There are two links in the causal chain by which the tax treatment of employer-provided health benefits contributes to wasteful inflation in health expenditures. The first is that the preferential tax treatment causes firms to provide more coverage, and different types of coverage, than they would in the absence of the tax preference. The second is that expanded coverage with few internal cost controls causes providers to deliver more services, and more expensive services, than they would if consumers had different insurance coverage. These two links are well established by a number of studies of the demand for health insurance and of the relationship between insurance and use of health services, conducted by the Rand Corporation and other research institutions.

Considering both income and social security taxes, employer-paid health benefits are "purchased" at a typical discount of about 40 percent compared to goods and services that must be paid for with after-tax dollars. It is no wonder that employer payments continue to rise at rates far beyond general inflation levels. When services are covered by insurance, neither consumers nor providers have much reason to restrain utilization, and both prices and quantities of services are forced upward, leading to inflation in health expenditures.

It is an illusion to suppose that workers are protected against paying for these inflated expenditures by their insurance coverage. They most certainly do not pay in the form of forgone wage increases eaten up by higher health benefits payments. And all of society pays dearly for increases in health expenditures that do not contribute to a healthier population.

Until recently, employers have had little incentive to intervene in this process because health care costs have historically been a relatively low fraction of total labor costs. The rapid rise in these payments has caused many employers to take steps to institute redesigned health benefits and more aggressive plan management. Until the current tax preference is limited, however, we may expect increasing health expenditure inflation from this source.

Opponents of the tax cap have expressed skepticism that this proposal will bring about changes in insurance coverage and in the prices and amounts of health services consumed. This skepticism does not give full consideration of the behavioral implications of a 40-percent discount. Indeed, the preferential tax treatment is defensible only under the assumption that it does encourage employers to provide health insurance as a fringe benefit.

Analysts who have examined the tax cap proposal in the Administration, the Congressional Budget Office, and private research organizations conclude that it will bring about a change in employer-paid health benefits and a lower rate of inflation in health expenditures than would be the case under current law. Although it is a difficult and imprecise task to determine the exact magnitude and timing of these changes, my office estimates that in 1990 the tax cap will produce over $20 billion in savings in employment-based health expenditures. We feel that this is a conservative estimate and that the savings will continue to grow over time.

EMPLOYER RESPONSES TO THE TAX CAP

Some employers, principally those with very deep and broad health benefits, will be required to decide whether and in what manner to respond to the prospect of exceeding the tax cap.

One response is simply to accept the new tax liability and add excess health benefits to employee income for the purpose of withholding and taxation. This is clearly not an ideal response from a health policy perspective, but at least it does accomplish the goal of placing extensive benefits on an equal footing with other forms of taxable compensation. Inflationary forms of health care financing would no longer be completely tax sheltered.

A similar response would be to reduce the employer contribution so that the cap is not exceeded and increase the employee share by an equal amount. This strategy would be expected to be accompanied by increases in (taxable) employee wages. It, therefore, has the same tax impact as the first option, although it is unclear whether it would appear the same to employees.

The more interesting and constructive employer responses involve reforms in the way health benefits are structured and health plans are managed. Herein lies the real promise of the tax cap to encourage structural and procedural changes that will both save money and enhance private sector efforts at health promotion.

A relatively simple method of reducing costs of coverage is to increase deductibles and/or coinsurance, keeping benefits and plan management the same. Deductibles have increased relatively little over the past several decades, and the impact of coinsurance has lessened as more and more plans add out-of-pocket maximums to their benefits packages. This "cost-sharing" strategy has been adopted by a number of firms seeking to reduce health care costs. It will reduce not only the firm's share of employee health care costs but also the rate of increase in total health care costs.

Several studies have shown that an increase in cost sharing would bring about a reduction in health service expenditures. The most conclusive of these studies, the Rand Health Insurance Experiment, is funded by the Department of Health and Human Services. More detailed findings from the Rand study on the relationship between cost sharing and specific types of health care utilization and health outcomes are expected over the next several months.

Some firms, for a variety of reasons, may prefer not to adopt the cost-sharing strategy or wish to supplement it with other cost containment efforts. A number of other options are available. One approach is to redesign health benefits to bring about more cost-effective use of health services. Expansion of coverage for ambulatory services and surgical second opinion programs, for example, has led to some claims of cost savings, even though this approach represents an increase in benefits. Other benefit redesign options, such as medical expense account programs, give employees financial incentives not to overuse covered services. Still another approach is to give employees a choice of benefits in the hope that some employees will choose plans with better controls on utilization.

Employers may also encourage the use of cost-effective providers to save money while maintaining coverage levels. Health maintenance organizations (HMO's), for example, have been shown to provide health benefits in a cost-effective manner.

HMO's restrict subscriber choice of providers to those who are a part of the organization. Preferred provider organizations (PPO's) give employees a financial incentive to use the services of efficient providers, but they also reimburse employees for services obtained from providers who are not part of the organization. Some employers also attempt to steer employees in the direction of efficient providers without a financial inducement.

Identification of efficient providers requires developing a data collection capability that enables employers to discriminate between appropriate and excessive utilization and prices. In some parts of the country, coalitions of employers have formed which, among other things, develop comprehensive data bases on provider pricing and treatment practices in their respective market areas.

Private utilization review is another data-intensive activity that has great cost-saving potential. Typically, third-party administrators review claims to identify "exceptions" and follow a prescribed course of action to justify or correct what appear to be inappropriate services or charges. Regardless of what sanctions are ultimately applied, proponents of this approach claim that it achieves cost savings by changing the behavior of providers who are prone to excess.

A final approach that employers may take is to become directly involved in enhancement of employee health. Worksite health promotion and disease prevention programs have been claimed to save health benefits dollars and to reduce absenteeism and turnover as well. Workplace programs include screening for early detection of disease, classes and other activities to encourage healthy lifestyles, and in some cases direct provision of health services.

It is a hopeful sign that private industry is currently experimenting with a variety of ways of holding down health expenditure increases. The tax cap is entirely consistent with this trend—the financial incentives embodied in the cap will encourage more employers to adopt cost-saving innovative practices. More employee cost-sharing, more carefully selected plan benefits, and more aggressive plan management will combine to slow the rate of increase in health expenditures.

CONCLUSION

In conclusion, Mr. Chairman, I would like to emphasize the following points:

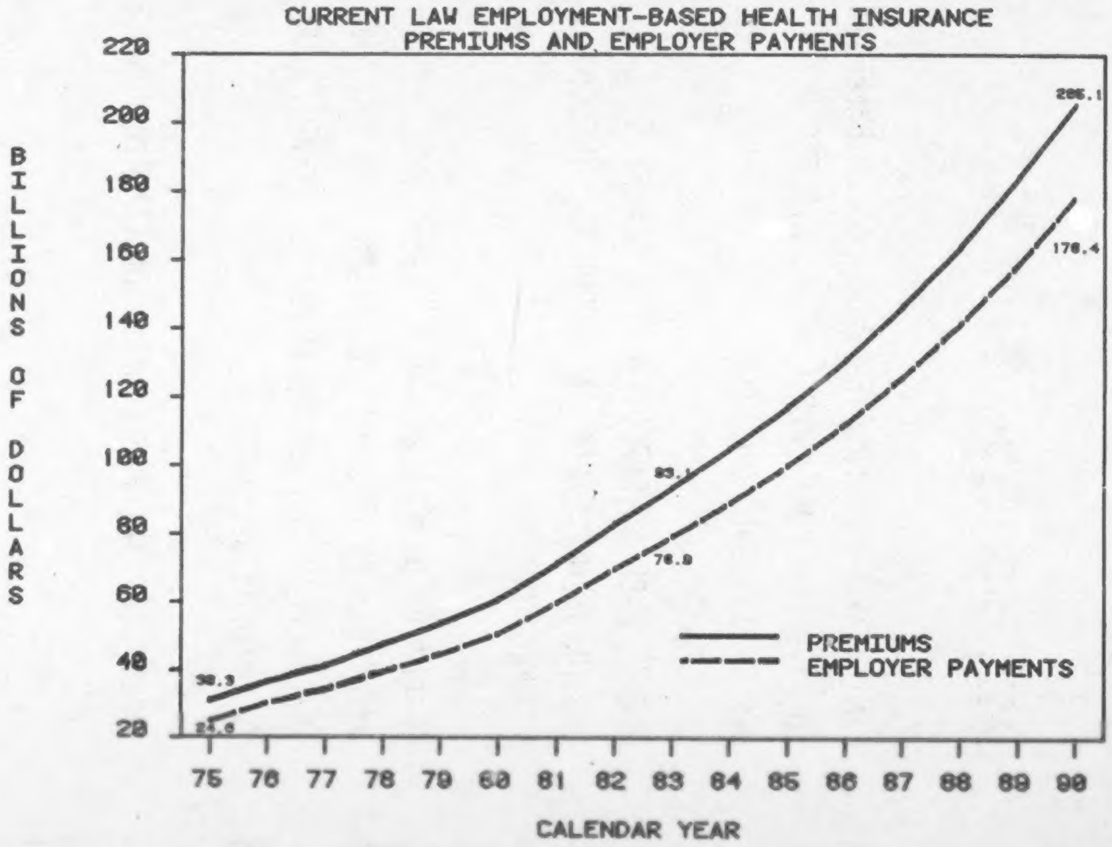
First, the current tax treatment of employer-paid health benefits is unfair and the inequity is getting worse over time. It is unfair to the unemployed and to others who do not have this form of nontaxed income available to them. The current tax preference goes far beyond its original intent of encouraging protection against the financial consequences of serious illness. It is increasingly becoming a tax loophole for high-income workers.

Second, current law contributes significantly to inflation in private health expenditures, most of which are financed by employers. Available evidence establishes the chain through which the tax preference encourages excessive and inefficient insurance coverage which, in turn, fuels inflation in health expenditures. These rapidly rising health expenditures are doing little to improve the nation's health.

Third, this problem is getting worse at an alarming rate. Current law projections indicate that inflation in employer-paid health expenditures will increase dramatically in the 1980s.

The tax cap is a modest proposal. It does not prescribe a particular cost-containment technique but rather limits the tax law's distorting effect on private activities in an important sector of the economy. It should be viewed as a catalyst to effective private health care cost containment, and a useful complement to our efforts to improve the efficiency of Medicare and Medicaid.

Equally important, it would not adversely affect low income people. Instead, it would help assure that all Americans—the privately insured, as well as Medicare and Medicaid beneficiaries, participate in our efforts to control health care inflation.



CURRENT LAW EMPLOYMENT-BASED HEALTH INSURANCE
PREMIUMS AND EMPLOYER PAYMENTS

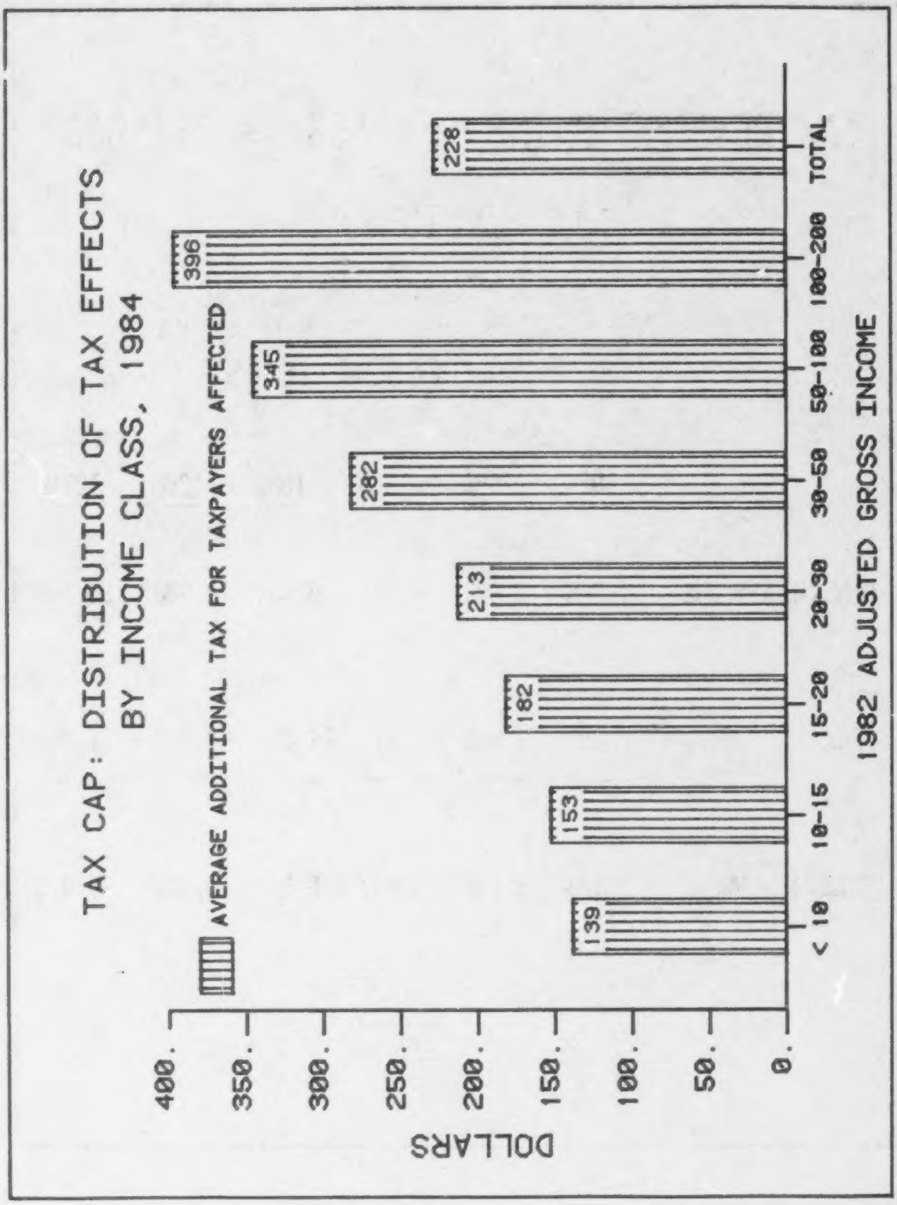
BASIC PROVISIONS OF THE TAX CAP

- LIMIT TAX-FREE EMPLOYER-PAID HEALTH BENEFITS TO $175 PER MONTH PER FAMILY, $70 PER MONTH PER INDIVIDUAL, IN 1984.
- TREAT "EXCESS" EMPLOYER-PAID BENEFITS AS ORDINARY INCOME FOR TAX PURPOSES, INCLUDING WITHHOLDING.
- EFFECTIVE DATE: JANUARY 1, 1984. EMPLOYERS WITH LEGALLY BINDING CONTRACTS THAT FIX THE HEALTH PLAN CONTRIBUTION MAY BE EXEMPTED UP TO JANUARY 31, 1986.
- ANNUAL CAP INCREASES BASED ON CONSUMER PRICE INDEX.

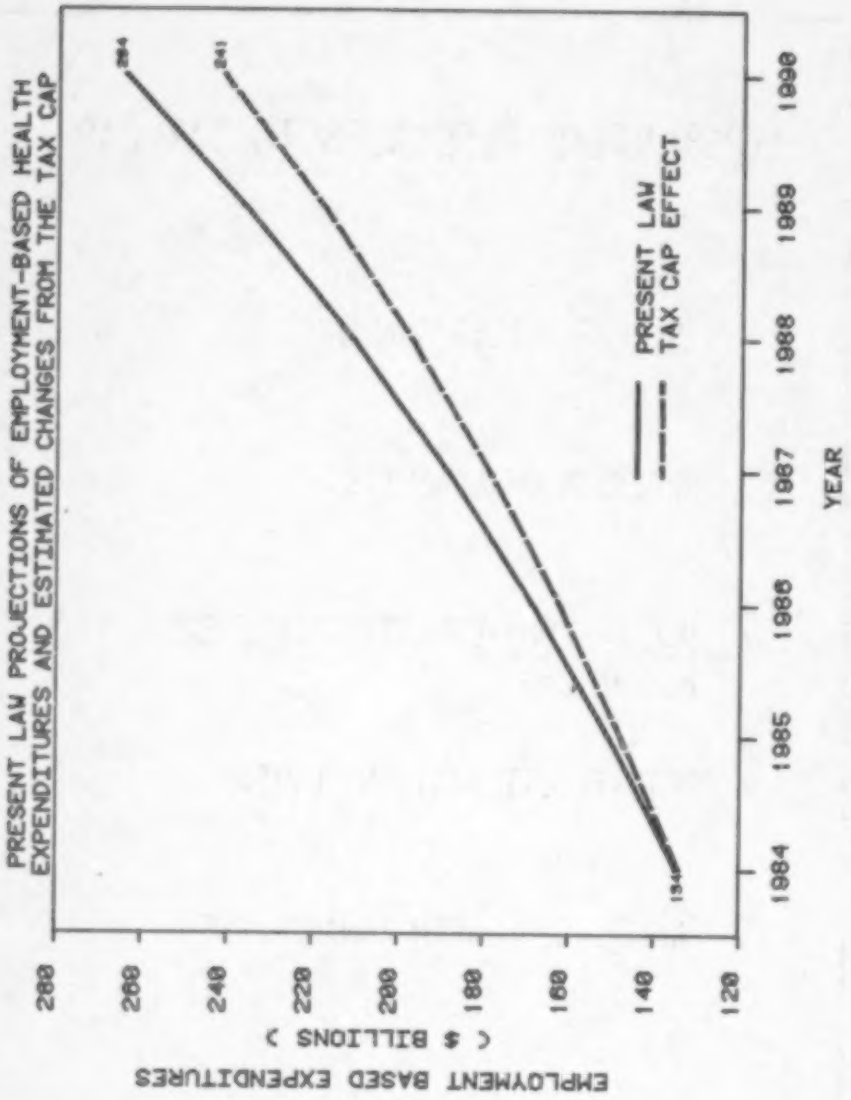
TAX REVENUE GAINS: FY 1984 - FY 1988

($ MILLIONS)

	FISCAL YEARS					
	1984	1985	1986	1987	1988	TOTAL
GENERAL REVENUES	1,546	3,092	4,141	5,064	6,306	20,149
FICA	562	1,098	1,476	1,804	2,323	7,263
TOTAL REVENUE	2,108	4,190	5,617	6,868	8,629	27,412



TAX CAP: DISTRIBUTION OF TAX EFFECTS
BY INCOME CLASS, 1984


PRESENT LAW PROJECTIONS OF EMPLOYMENT-BASED HEALTH EXPENDITURES AND ESTIMATED CHANGES FROM THE TAX CAP
EMPLOYMENT BASED EXPENDITURES ($ BILLIONS)
280
260
240
220
200
180
160
140
120
YEAR
1984
1985
1986
1987
1988
1989
1990
264
241
134
PRESENT LAW
TAX CAP EFFECT

POTENTIAL RESPONSES TO TAX CAP

- INCREASED COST SHARING
- REDESIGN OF BENEFITS
- USE OF COST-EFFECTIVE DELIVERY MECHANISMS
- PRIVATE UTILIZATION REVIEW
- WORKPLACE HEALTH ENHANCEMENT

Senator PACKWOOD. Doctor, on the bottom of page 8 and the start of page 9 of your testimony I think you reveal what you hope will happen if the cap is created. You put on a cap, and the natural inclination of the employer and of the union bargaining agent will be to try to come down to that cap and perhaps do it by increasing deductibles or coinsurance. Do I presume that is what you think is going to happen? You list a variety of options, but that is the one you seem to give the most preference and hope to.

Dr. RUBIN. Well, that is certainly what history seems to teach us. Hay Associates has just completed a survey, on what employers are doing to control their health care costs. What they found is that about 13 percent of surveyed firms have recently increased their deductibles, and about another 21 percent were considering such an increase. Roughly 23 percent had also increased their coinsurance or were considering an increase in their coinsurance.

So certainly that is one type of response. I think that there are other plans though—other companies—that have looked very carefully at restructuring their plans to provide more catastrophic and so-called "back end" insurance and less first dollar, no-questions-asked comprehensive coverage. We would hope that both factors would be at work there.

Senator PACKWOOD. And you presume further that if the employer drops their health insurance payments to $175 a month, that there will be no way they can avoid paying the difference in increased wages? They won't be able to simply reduce their costs by that amount, is that correct?

Dr. RUBIN. Either wages or other forms of nonwage compensation, yes.

Senator PACKWOOD. Well, let me ask you this: If they do it in the form of other nonwage compensation or if they shift it over into other nontaxable fringe benefits, which they have a fair amount of room to do, then how does the Government gain any revenue from this?

Dr. RUBIN. I think that was the nub of your question to Mr. Chapoton asking for the assumptions based in our cost estimates. And as I think he indicated, there are certainly some assumptions about shifting in the long run into cash wages. There is also a smaller percentage that is built into the assumptions in terms of a shift into nontaxable fringe benefits, and as he indicated the Treasury Department will be providing those figures to you.

Senator PACKWOOD. Now, to the extent that the cap works as you hope—let's assume you reduce it to the $175 and you increase the deductibles so that the employee is going to have to pay more of the first dollar cost, or first $100, or first $500 of cost—does not that indeed unfairly impinge on the lower wage employees?

You expressed a concern in your statement earlier about the bias of health plans toward high-wage employees. Doesn't a flat deductible discriminate against lower wage employees?

Dr. RUBIN. Well, certainly a flat deductible may well do that. But what we have seen is that some companies—for example, Xerox—are not doing that. Instead, they are linking their deductible or the coinsurance to some sort of income determination by category within the company. Under that circumstance these would not be discrimination against lower-income workers.

Senator PACKWOOD. That is true, although, as I say, 5 years ago I did not have the votes to get rid of that discrimination.

But what you are saying then is that employer provided benefits would on the average be lowered to the $175 cap. And as a result, the $50,000 employee may have $1,000 deductible, and the $15,000 employee may have a $100 deductible.

Dr. RUBIN. As a hypothetical, sure.

Senator PACKWOOD. But you won't be able to have that if you get rid of the discriminatory provisions.

It seems to me you've got a Hobson's Choice. If you get rid of the discriminatory provisions, the deductible discriminates against the low-wage employee. If you don't get rid of the discriminatory provisions, then the whole plan tilts toward the high-income employee.

Dr. RUBIN. Well, the other piece of that, of course, is that there are other alternatives that we know are cost effective ways of delivering health care that in general don't have deductibles or coinsurance.

For example, in northern California, the Kaiser health maintenance organization, for about $140 per month per family, will provide comprehensive hospital coverage without patient cost sharing, comprehensive medical coverage with a maximum copayment of $1 for an office visit; and preventive health services, mental health benefits, et cetera.

Senator PACKWOOD. But now you are talking about a whole different subject, and that is the relative cost of an HMO delivering services versus a non-HMO.

Dr. RUBIN. No. I think what we are talking about here is making employees and employers aware of the full range of options. By providing the most cost-effective benefit programs for their employees, employers can maintain the full level of benefits and still come in under the cap, regardless of the employee's salary level.

Senator PACKWOOD. I am very, very familiar with the Kaiser plan—they are a large plan in Oregon. Henry Kaiser came in during World War II at the shipyards and covered his employees. And today, believe it or not, in the State of Oregon the Kaiser health plan is the eighth biggest employer in the State of Oregon, which gives you an idea of the magnitude of its coverage.

I have visited their hospitals and their plants. I have a high regard for them. But I think you are talking about two different subjects, because they have proven that they can provide a certain kind of health care to the satisfaction of employees. That, I find, is a different subject from the health cap.

Senator Durenberger.

Senator DURENBERGER. Bob, let me address a couple of the concerns I think that have been expressed about the proposal. A lot of employers, with prodding from health care providers on the outside, have incorporated a much wider variety of coverage than just doctor/hospital coverage, and there is much more preventive coverage in these health plans today. That is certainly laudable, but it is also one of the things that has expanded not only the coverage but the cost.

One of the criticisms is that by putting a premium cap on we are going to see preventive services dropped out of these plans. What is your reaction to that?

Dr. **Rubin**. Well, last year private health insurance increased at the highest rate in our history—about 16 percent. And it is instructive to look at what the employer response has been.

Last year was just one among many where the increase in employer premiums for health insurance has gone up dramatically, and we certainly don't see employers paring back, almost like an onion skin, in these preventive programs; what we see them doing is looking very carefully at the kinds of programs that they are providing.

And in contrast to what Senator Packwood said, I think that HMO's really get to the nub of what we are talking about, which is to increase cost consciousness among both employees and employers.

Employers have not cut back on preventive services, and indeed one could make the argument that they wouldn't be expected to, because that's the kind of thing that would keep their annual increase for health insurance down. And they haven't cut back on the so-called frills that people talked about—drug coverage, dental coverage, et cetera. What they have done is restructured their plans in a much more actuarially sound way, with coinsurance and deductibles, et cetera.

Senator **Durenberger**. You mentioned the HMO's, and another one of the criticisms—and this does come from the HMO's as well as others—is that somehow or another the cap is going to interfere with the development of health maintenance organizations. [PPO's] some of the other prepaid health systems.

Now, we have had an experience here with the Federal employees health benefit plan in which we've got a cap already. Right now our cap as Federal employes is about, $103 a month. But HMO growth has been relatively substantial. What is the reason for that? Are the HMO people wrong when they say that a premium cap is going to interfere with their development?

Dr. **Rubin**. I do think that they are wrong. I don't think that this will interfere at all with HMO development. I think it is noteworthy that if one looks, for example, at southern California, which is one of the highest cost medical markets in the country with costs 80 percent above the national average, Kaiser, again, would come in only slightly above our cap in a situation where the rest of the health care system is strikingly above our cap.

We have also taken a look at the FEHBP plan, and many of the HMO's have premiums near or below the proposed cap.

And remember what those plans are being compared to in the private market. Their direct competitors, in terms of benefits, are traditional fee-for-service plans that provide extraordinarily rich benefit packages. In my judgment, these fee-for-service plans would, in most areas, particularly in the high cost areas, come in way above the cap and the HMO premiums. So I think HMO's would be in a very beneficial position under our proposal.

Senator **Durenberger**. Thank you.

Senator **Packwood**. Senator Bentsen.

Senator **Bentsen**. Dr. Rubin, you speak of substantially curtailing and lowering health costs, and yet at the same time you talk about a $27 billion increase in revenue. Don't the two work against each other? How do you achieve that—substantially lowering health care costs and yet increasing your revenue that much—unless you are taxing basic health needs? Or at least what is perceived as that by the general public.

Dr. Rubin. I think if one takes a look at the cumulative savings in the period of 1984 to 1990, we are talking about cumulative savings in health expenditures as roughly $75 billion.

Senator Bentsen. But at the same time you are talking about increasing your tax collecting, the revenue, by some $27 billion.

Dr. Rubin. Right.

So what I think we are seeing here is——

Senator Bentsen. Aren't you then getting to the basic health needs of people, at least as they perceive them, and taxing that?

Dr. Rubin. No, I don't believe so. We asked a firm to estimate what we could purchase on average throughout the country for $175 per month. And I think it is very instructive to take a look at that.

For about $175 a month, again nationally, you would get full room and board and surgery coverage, supplemental coverage with 20 percent coinsurance and a $100 deductible, plus a dental plan. Now, I don't think that that really gets into basic coverage.

Senator Bentsen. Well, now, you get into my next point then, when you say you looked at it across the Nation. Don't you run into some problems insofar as the one region of the Nation being favored over another, based on what their costs are? Or one particular job classification or industry having a premium that is much higher than another one because of the type of work done? Don't you run into a problem with various age groups that might be associated with a particular company? How do you deal in that and establish equity when you put an arbitrary cap on of $175 and $70?

Dr. Rubin. Well, I think in terms of the regional situation, what we need to understand is that first of all there are variations in medical practice patterns. That is to say that clearly wage rates are different in parts of the country and real estate costs are different in parts of the country, et cetera.

But if you take all of that into account, you still can't account for the vast difference in health care costs. So to say that some people will have to do more to come down to what an efficient level of care is, I think is to some extent begging the issue. It is precisely what the tax cap is designed to do.

I think that there clearly is variation in the availability of resources in terms of hospital beds, technology, et cetera, that determine what that cost of care will be. Some regions have easier access to sophisticated care and thus have higher health care costs. It is not "unfair" for the tax cap to pinch more in these areas than in say rural areas with less expensive facilities.

I think, clearly, under those circumstances it makes sense to have a uniform cap across the country. If Mr. Chapoton were here, he would point out all the tax reasons why we oughtn't to have variations, but I will leave that to him for a different occasion.

Senator Bentsen. I want to get to the point of the older workers. How would you address that problem, putting the arbitrary cap on as opposed to the company that might have younger workers?

Dr. Rubin. I think one has to look at the fact that companies hire older workers for a variety of reasons—for example, longevity gives older workers a certain increase in productivity, certain skill levels. Furthermore, the added tax liability from the tax cap would be small relative to total employee compensation. If one looks at the employee's total compensation package, the added taxes from a health plan as much as $500 over our cap amount would amount to less than 1 percent of the compensation of an employee receiving $15,000 annually in wages and benefits.

So I don't see that a company would make that determination that they need older workers or they don't need older workers solely on the basis of what that is going to do to their group-rated or experience-rated health insurance premiums.

Senator BENTSEN. Well, I understand that. But it seems to me that you really put the squeeze on the older workers insofar as the limitation.

Dr. RUBIN. No, because those costs are spread over the entire company. So it amounts to somewhat inconsequential in terms of dollars-per-worker over the entire company.

Senator BENTSEN. Thank you.

Senator PACKWOOD. Senator Long.

Senator LONG. No questions.

Senator PACKWOOD. Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman.

Let me ask you, Dr. Rubin, does it make any sense to exempt preventive medicine here, preventive services?

Dr. RUBIN. Yes, I believe it does make some sense.

Senator BRADLEY. How would you do that?

Dr. RUBIN. We would look to exempt care that is provided by an employer and that is episodic in character. A good example would be the nurse and the physician that is provided for emergencies that may occur within these buildings. Similarly, at the Department of Health and Human Services we have a nursing unit. Clearly, I think those things are things that make some sense.

Also, we would exempt from the cap employer-provided care as required by law. In other words, an OSHA requirement. We would also exempt health-promotion activities that are not generally paid through health insurance—for example, all over the country employers are looking to health promotion activities by providing running tracks or swimming pools, that sort of thing, for their employees. We wouldn't count that or amortize that as part of a health benefit expenditure.

Senator BRADLEY. What percent of the working population now has health benefits above $175 per month?

Dr. RUBIN. We estimate that in calendar year 1984 roughly 30 percent of the working population that receives employer-based health insurance would have benefits above $175.

Senator BRADLEY. Thirty percent—what is that in numbers?

Dr. RUBIN. That would be about 45 million people if you include the dependents of workers.

Senator BRADLEY. Forty-five million people are above the cap now?

Dr. RUBIN. Right.

Senator BRADLEY. And this goes into effect when?

Dr. RUBIN. This would go into effect January 1, 1984.

Now, under the grandfather clause, Senator, only about a fifth of workers would be affected, so that the 30 percent comes down to about 20 percent. We are talking about 30 million people, including dependents.

Senator **Bradley**. Thirty million people?

Dr. **Rubin**. Right.

Senator **Bradley**. What happens if you entered into a collective bargaining agreement for 4 years in 1983, and then we pass this tax cap, and suddenly you were in that 30 million people who gave more generous than what the cap is? Wouldn't that result in a decrease in income or an increase in taxes for you?

Dr. **Rubin**. It wouldn't until the last year. The tax cap would not be effective for such a collective-bargaining agreement until January 31, 1986.

Senator **Bradley**. So if indeed there was a 4-year agreement in 1983, that in the last year, without the ability to go back to the collective bargaining table, you would essentially be raising the taxes on 30 million people.

Dr. **Rubin**. Well, no, not exactly.

Senator **Bradley**. Well, however many were in that group.

Dr. **Rubin**. And that would assume that, given the indexing provisions in the bill, that the collective bargaining number would exceed the cap even after indexing over those periods.

Now, I am told that there are very few collective bargaining agreements that extend greater than 3 years, which was the reason that 3 years was picked.

Senator **Bradley**. That's why you picked the 1986 target date?

Dr. **Rubin**. Yes.

Senator **Bradley**. For when this would go into effect.

Dr. **Rubin**. Three years after enactment.

Senator **Bradley**. What are your thoughts about how this would affect different industries with different levels of danger in the industries? For example, let's say you are a coal miner. If you are a coal miner, you have a little different series of health needs and health costs than if you were a retail clerk in a department store. Would the $175 cap discriminate against the more dangerous industries?

Dr. **Rubin**. Well, if one takes a look at the percentage of workers affected by industry, with the possible exception of mining——

Senator **Bradley**. But that's the example I gave, so use mining. [Laughter.]

Dr. **Rubin**. Well, for example, I'm not sure that the entertainment or recreation industry is any more or less dangerous than the sales business. And yet, clearly, there are more workers in entertainment and recreation that are affected than in the sales force.

In terms of the mining business, there are several things that one needs to take into consideration. First is that I think it would be very difficult to compare the kinds of insurance programs that people in that industry might have. It turns out that in the example you chose, in mining, there is very little in terms of coinsurance or deductibles, or——

Senator **Bradley**. Health care costs are higher, though, right?

Dr. **Rubin**. It is less clear that health care costs are higher in a particular industry. In other words, to say that the industry would fall above the cap does not necessarily correlate with an individual's health care costs.

Senator **Bradley**. What is the value in the mining industry's health insurance?

Dr. **Rubin**. I don't know.

Senator **Bradley**. You don't know?

Dr. **Rubin**. Do you mean the dollar value?

Senator **Bradley**. Yes.

Dr. **Rubin**. I can't give you the precise numbers, Senator.

Senator **Bradley**. But, clearly they fall in that 30 million figure, don't they?

Dr. **Rubin**. Thirty-six percent of workers in the mining industry would be affected by the tax cap.

Senator **Bradley**. But you don't know what their level is?

Dr. **Rubin**. No.

Senator **Bradley**. Well, then, how do you know they are affected?

Dr. **Rubin**. We can provide for the record the precise dollar amounts, but based on our surveys 36 percent is the percentage of workers affected. At this time I do not have the figures.

Senator **Bradley**. OK. Well, it is kind of troubling if you are going to have a very uneven impact across different sectors. That's the point I was making.

[The information follows:]

In 1984, the average employer health plan contribution in the mining industry will be about $190 per month per family and $70 per month per individual.

These estimates were calculated using data from the National Medical Care Expenditure Survey (NMCES), a 1977 survey of 20,000 individuals. To arrive at 1984 estimates, 1977 data on employer contributions were inflated to reflect the intervening increase in the cost of employment-based health plans.

Although the NCMES survey provides the most comprehensive and reliable information on employment-based health insurance, it should be used with caution. Disaggregating the national data to estimate health plan costs in particular industries is particularly problematic. In the mining industry, the number of surveyed individuals was small, which increases the likelihood that the respondents are not representative of the entire industry.

In developing a response to this question, the HHS Office of Planning and Evaluation contacted the Bituminous Coal Operators of America (BCOA) to obtain their estimate of health plan costs in the coal mining industry. BCOA was reluctant to provide such data for the public record, since the industry's collective bargaining agreement expires next year. The outcome of those negotiations may affect the average health plan contribution in the mining industry in 1984.

Senator **Packwood**. Senator Chafee.

Senator **Chafee**. I have no questions.

Senator **Packwood**. Well, let me pursue what Senator Bradley was saying.

You are not suggesting, Doctor, that this discriminatory cap, as I call it, is going to fall equally on all segments of industry, are you?

Again I will go back to my labor relations days. There were unions that had on the average older employees than other unions. And my hunch is that you will still find this in industry today—whether it is geographic or whether it is by industry—that certain employers simply have on the average older employees than other employers do.

Dr. **Rubin**. That may well be. I think that if you would take a look at which industries are affected, you will see that the effect may not have very much to do with either the age of the workers or the danger involved in those particular occupations.

Senator **Packwood**. It isn't danger so much in the sense of workers compensation and injuring yourself; it's that as you get older, on the average you have higher health costs.

Dr. **Rubin**. Well, that's certainly true.

Senator **Packwood**. So if you've got an employer that on the average has an older work force, that employer, if they have a $175 cap, is going to find it a lot rougher on his or her employees than one that has a younger age category in their employ.

Dr. **Rubin**. Senator, at first you said industries may vary in age composition. I think that is a lot more difficult point to make than to say that clearly certain employers within individual industries may well have a different age distribution among their employees. And certainly if, in point of fact, firms have higher expenses and are experience-rated, they certainly will have a higher premium, and they will be more likely to bump up against the cap.

Senator **Packwood**. I think I heard what you said. Say that again.

Dr. **Rubin**. I said that I think you need to draw two distinctions variations. Your first comments spoke to industrywide variations. You said something to the effect that industries may age in a disproportionate way.

Senator **Packwood**. Then let me rephrase it.

There are certain industries in this country that on the average will have higher age workers than other industries. I am not talking about within the industries. I don't know if Bethlehem Steel has on the average older or younger employees than United States Steel. But there are certain industries that have demographically higher age groups working than others.

My hunch would be—I don't know; I've never looked at it—that the average age of McDonald's employees is younger than the average age of United States Steel's employees. [Laughter.]

Dr. **Rubin**. That's probably true. And I think that the question really goes to whether or not——

Senator **Bradley**. Don't go out on a limb on that. [Laughter.]

Dr. **Rubin**. I would probably say that—I'll take your advice. Thank you. [Laughter.]

Dr. **Rubin**. There is no question that that is correct.

Senator **Packwood**. OK. So we've got discrimination.

Dr. **Rubin**. No, not exactly, Senator.

But then let me ask the following question of you: If we have a higher concentration of McDonald's hamburger places in southern California, which is a high-cost area, then that whole business about their having a preference because they're younger may be ameliorated to some extent.

Senator **Packwood**. I was going to come to that next. You've got no distinction in this bill between high cost and low cost medical service areas. You've got the same cap in a town of 3,000 that you have got in a town of 3 million.

Dr. **Rubin**. We also have the same income tax brackets; that's true.

Senator **Packwood**. I understand that. So we are going to discriminate on age and we are going to discriminate on high-cost versus low-cost areas. At the moment there is no discrimination in those areas, to the extent that you have a health plan that has the same deductible in a town of 3,000 as a town of 3 million.

Dr. **Rubin**. Well, I'm not sure that that's correct based on the cost experiences.

Senator **Packwood**. I am talking about the employee. Granted, the employer may be paying more for health insurance premiums in New York City than they may be paying in Newport, Oreg.

Dr. **Rubin**. Right.

Senator **Packwood**. I am talking about the employee, assuming that you have the same benefit structure, that they don't have to worry about whether they are discriminated against because they come from a small town or a large town.

Dr. **Rubin**. Well, I would point out that clearly the general Internal Revenue Code does not take into account regional cost differences. To use your word the code "discriminates" against people who live in high-cost areas such as New York or Washington or Boston, versus people who live in towns of 3,000. Presumably—and certainly the economists that you have later on today will tell you that—the higher expenses of those living in high-cost areas are taken into account in their total compensation package. But, not being an economist, I wouldn't want to posit that.

Senator **Packwood**. You may be right. I have often thought that the lawyer who has the best living in this country is one who lives in a town of about 50,000 who is able to make $125,000 to $150,000 a year, as opposed to a Manhattan lawyer doubling that salary but having to live in Manhattan.

Dr. **Rubin**. It is generally true for physicians in that situation. [Laughter.]

Senator **Packwood**. I have no further questions.

Dave?

Senator **Durenberger**. No.

Senator **Packwood**. Lloyd.

Senator **Bentsen**. I have.

Of course, Internal Revenue does take it into consideration, and they do it on expenses. And the question is, is that particular type of expense in line with the costs in that area? So they do take it into consideration.

Let me get back to the point that I originally raised.

Dr. **Rubin**. That's only for taxpayers that itemize their deductions, which is a very small percentage of Federal taxpayers. I'm not sure itemizers are the group that Senator Packwood was referring to as being relatively lower wage earners.

Senator **Bentsen**. But let me refer specifically back to the point that I raised earlier, and that's discrimination on age.

If you are in a declining industry, and obviously generally have older workers, and you allow the exemption up to $70 or $175 on the family, obviously that premium is going to be substantially larger on that older worker. And that's not spread over the company; that's spread to the individual employee. He ends up paying an additional tax.

Mr. **Rubin**. That's not accurate, Senator. It is spread over the entire employee group.

Senator **Bentsen**. That's right. And if they are an age group, then the amount of excess will be more—if they are an older age group—and each of those employees finds that excess then included in his gross income. OK?

Dr. **Rubin**. That's true. But the excess is identical whether you are 63 or 43.

Senator **Bentsen**. I understand that very well. That point I wasn't arguing. The point I was making is that you have an age group with a substantially older age effort, and therefore a substantially higher premium for all of them. I well understand how the system works. And that ends up putting the squeeze on the older worker.

Dr. **Rubin**. Well, to the extent that the older worker is compensated equally with the younger worker, which most industries in this country——

Senator **Bentsen**. But that is not the case that I referred to. I talked to you about declining industries where you have a situation where the workers in general are older workers. In that kind of a situation I think that you unquestionably are punching the older worker. You are making it more difficult for them to have adequate health care.

Dr. **Rubin**. Not at all, Senator. I think it is important to keep in mind that it is not the goal of the tax cap to accommodate a rich plan of benefits, fully paid by the employer, for all workers in this country.

Senator **Bentsen**. That's not the question at all. It is an adequate health care benefit that they are talking about. And when you get to that group of older workers in a particular company in a declining industry, then I think you are going to see substantially less-adequate health care as opposed to a relatively young group in another company. And, as you just stated, those costs escalate substantially for the older worker.

Dr. **Rubin**. Well, there's no question but that in a group experience plan, if you have young males as opposed to an older group of mixed sexes, that you will have less health care costs—no question about that at all.

In terms of the adequacy of plans, as I indicated earlier, you can get hospital, physician, supplemental coverage and a dental plan for $173, on average, across this country. That is certainly an adequate plan.

Senator **Bentsen**. I am not talking about the average. I have made that point several times now.

Senator **Packwood**. I know we have more questions. We have about 12 more witnesses to finish this morning, so I think we had better start to try to hold our questions down.

Senator Long.

Senator **Long**. No questions.

Senator **Packwood**. Senator Bradley.

Senator **Bradley**. Just one question.

Taking Senator Bentsen's example, the declining industry, let's say that the person loses his or her job, as a lot of people have in steel and autos in the last couple of years, and they go to another job. And we have a $175 cap. And because they are older, their health care costs are not average, but they are more. What leverage does that person have to get their wages that much higher to take into account what they have lost by the cap?

Dr. **Rubin**. Well, Senator, when somebody changes jobs or accepts a new job, he or she generally accepts the total compensation package offered by a particular employer. That's what it is, going in. If, on the other hand, the worker has some ability to negotiate wages and benefits, he or she certainly can attempt to do what you have suggested. To the extent that they can't, they won't.

But it seems to me that it's not a transferable thing. If I make substantially more than I make as a Government official being a private physician, when I come to service in Washington, I know going in what my salary is going to be, and I make that decision presumably without any coercion.

I think when these workers move to accept a different job, they certainly know what their compensation package is and they know what their fringe benefit package is. It may be higher, or it may be lower.

Senator **Bradley**. But their health care costs will be greater.

Dr. **Rubin**. If you assume that the older you get the more health care costs, obviously.

Senator **Bradley**. There is not any evidence of that?

Dr. **Rubin**. There is abundant evidence of that.

Senator **Bradley**. So when you go to negotiate, you have brought your newly acquired skill to ask that you be hired in the firm. The firm is going to consider what the total costs are, and health care costs are going to be significant. Everyone else in the firm doing the same job at a younger age with lower health care costs will gladly take a $175 cap, let's assume. But you can't afford to if you are 50 or 55 years old. How can you take a $175 cap and be adequately covered? You can't. So then you have to argue for higher wages.

Dr. **Rubin**. Well, I don't think that all of the assumptions in your example are particularly accurate or necessarily followed in the real world. But I just don't believe that's what, in point of fact, happens.

Senator **Bradley**. All right.

Senator **Packwood**. Senator Chafee? Any other questions?

Senator **Chafee**. I have no further questions.

Senator **Packwood**. Doctor, thank you very much.

Next we will move on to a panel of Richard Epstein, Dr. William Felts, Willis Goldbeck, and Michael Bromberg.

Gentlemen, do you want to go in the order that you are on the list, or have you worked out a different order among yourselves?

If not, Mr. Epstein, go right ahead.

STATEMENT OF RICHARD EPSTEIN, VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

Mr. Epstein. Good morning.

My name is Richard Epstein. I am senior vice president of the American Hospital Association. We appreciate the opportunity to share our views on S. 640 with the committee.

We favor S. 640 and the notion of a cap on the tax-free employer-paid health benefits. Because of the time constraints, I will make some comments and request that the prepared statement that we have submitted to the committee be included in the record. I would like, however, to make some comments based on questions that were also asked earlier this morning.

I think it's fair to say that on an issue of this kind that it is not difficult to array thoughtful arguments on both sides. And I think that's been well suggested by both the questions that have been put by the committee members as well as the responses that have been given by the two earlier witnesses, and I suspect that will be so for the balance of the day.

What it boils down to, it seems to me, is the trade-offs that those of us who are involved in and affected by this kind of issue are willing to make. And by that I mean what is the benefit to be derived by a particular proposal? And what is the price of the change that that proposal would involve?

I think it is helpful to us in approaching that if we could agree on what the issue is. And it seems to me, insofar as our position is concerned and the manner in which we view this, that the basic issue is the escalating cost of health care. And certainly this has been made abundantly clear as a high priority concern of the administration, the Congress, employers, labor, and of insurers. And certainly this is so of society as a whole.

I think, too, we can say that the Congress, with respect to the social security amendments that have just been enacted into law, has spoken on that issue with respect to the dramatic change that has been made within the system of paying for health care in the medicare segment.

The question, having agreed that the cost of health care has risen too rapidly, is how you solve that, and who does?

The tax cap as proposed in S. 640, it seems to us, is a fair, equitable, practical, and workable mechanism for all segments of this society to participate usefully in the solution of the problem of health costs, and the key to that is simply the matter of incentives.

What prospective payment represents is a mechanism for having changed the incentive for behavior on the part of providers—that is, on the supply side of the health delivery system, if you will. But that kind of a solution is clearly incomplete unless we also address the demand side of this equation of what contributes to escalating health care costs.

The beauty of S. 640 and the notion of a tax cap is that it is designed to, affect the behavior of those who put demands on the health system. And it would do it in two important ways:

One is that employees—prospective patients, if you will—become necessarily involved and conscious of the cost of the care that they seek or need.

And, second, in turn, responding to that, the employers who employ them and provide those plans necessarily also become involved in an incentive system to change their behavior.

All of this on a nationwide basis, will dampen and moderate—if you will—the demand on the system for health care on the demand side.

In the process of looking at this issue, there have been a number of concerns that have been raised on the other side.

Senator PACKWOOD. I am going to have to remind you that all other than the government panelists are held to 5 minutes in your statements in chief. Go right ahead and conclude, if you would.

Mr. EPSTEIN. I would like to simply conclude then by mentioning some of the arguments that have been made on the other side. And if these are matters which would lend themselves to questions by the committee, I would be very pleased to respond.

I have heard the comment made that benefits would be jeopardized and employees would lose benefits; the amount of coverage would be affected; that there is a danger that it might lead to national health insurance; there is a question about the quality of care; and all of this is quite apart from the next benefit of this bill, which is to generate revenue.

I don't know that generating revenue is exactly a problem in this society today, but to the extent that there is a concern about generating revenue as a result of this then it seems to me it would be most appropriate if that could be applied to finance the Federal participation in a program hopefully that will be enacted by the Congress with respect to health benefits for the unemployed.

Thank you very much.

Senator PACKWOOD. Thank you.

[The prepared statement of Richard Epstein follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Richard L. Epstein, Senior Vice President of the American Hospital Association (AHA). On behalf of our 6,300 institutional members and 35,000 personal members, I am pleased to have this opportunity to present our views on the proposal to place tax cap on employer-paid health benefits.

Under current law, an employer's contribution to an employee's health plan is a tax-free fringe benefit—second largest statutory fringe benefit in the tax code, with the revenue loss estimated to be $18.6 billion in fiscal year 1983 and over $20 billion in fiscal year 1984.

The AHA strongly supports legislation introduced by Senator Dole (S. 640), which would limit tax-free employer-paid health benefits to $175 per month for a family plan, and $70 per month for an individual employee plan. The limit would be indexed to increase yearly in proportion to the consumer price index. Employer contributions above these amounts woud be added to employee income and taxed accordingly.

This proposal would reduce the revenue loss to the U.S. Treasury by $2.1 billion in fiscal year 1984, $4.2 billion in fiscal year 1985, $6.0 billion in fiscal year 1986, $8.0 billion in fiscal year 1987, and $10.7 billion in fiscal year 1988.

More important, according to the Congressional Budget Office (CBO), medical care prices would be about 2-percent lower in 1987 than under current policies if a tax cap were enacted and increased accordingly in future years. For the 85 percent of the population with employer-based health insurance, spending on insured medical services would be an estimated 9 percent lower in 1987. Studies conducted by the National Center for Health Services Research (NCHSR) and many health economists also agree that such a proposal would help control health care cost inflation.

COST CONSCIOUSNESS

The current tax treatment of health insurance premiums has substantially increased the demand for comprehensive insurance that, in turn, has distorted the demand for hospital care, often encouraging more expensive procedures.

Excessive health benefits are inflationary; they insulate consumers, providers, and insurers from the cost consequences of health care decisions, contributing both to the use of inefficient forms of health care financing and delivery, and to the overuse of health services. A cap would remove the insulation that separates consumers from actual health costs, making them more cost conscious and encouraging them to demand more cost-effective care as well as less costly services.

We share the view held by many that patients, guided by their physicians, demand more services and more expensive services when a large part of their costs are offset by insurance. The combination of private health insurance and public programs such as Medicare and Medicaid now pays for the vast majority of health care services, with patients paying a small fraction of the cost.

While the cap would provide substantial federal revenues, it also would encourage employees to play a more active role in choosing health insurance coverage and to be more sensitive to cost implications in the exercise of that choice. A study conducted by NCHSR found that only 18 percent of Americans receiving health care coverage through employment-related plans now have a choice among plans. If a ceiling were placed on the tax exclusion, many employers probably would make a fixed-dollar contribution toward health insurance while offering employees a choice of plans.

A tax cap would create new incentives for employers to restructure benefit programs and include cost-effective preventive services in their health plans, including services that help reduce unnecessary hospital admissions. For instance, it might provide employers, insurers, unions, and individual workers the opportunity and impetus to: experiment with alternative models of health care delivery, develop benefit packages with built-in incentives toward lower cost care, develop benefit packages that target the most essential health services, and increase individual accountability for spending on health care. Options ranging from the use of preferred providers and prepaid capitation plans to comprehensive restructuring of the benefit mix may be considered.

FEDERAL SUBSIDIES FOR HEALTH CARE

Federal resources and commitment, whether through direct grants, appropriations, reimbursement for services, or through certain tax policies, all are important factors in the financing of health care. The tax cap proposal, in effect, would reduce the level of federal subsidy to middle- and upper-income individuals by $30 billion over the next four years. Without appropriate adjustments such as the tax cap, an even larger share of federal resources will go toward subsidizing the care of higher income individuals compared to the poor in the future. For instance, preliminary CBO projections indicate that by 1995, under current law, the federal government will be subsidizing those with employer-based coverage at a rate of $126.8 billion, while the Medicaid program, designed to benefit strictly low-income individuals, is projected to cost $58.4 billion that year by comparison.

NEED TO CONTROL PRIVATE HEALTH CARE SPENDING

The Social Security Admendments of 1983, P.L. 98-21, enacted prospective payment for inpatient hospital services under Medicare that will yield significant program savings. In addition, over the past few years there have been several changes designed to reduce Medicaid growth. As consumers, providers, the Congress, and the federal government continue to grapple with health care cost inflation, the importance of a tax cap becomes even greater. The tax cap is one approach that can have a direct impact on controlling private health care spending, which represents 57 percent of all national health expenditures. Reducing the rate of inflation in health care means addressing not only Medicare and Medicaid, but private health care spending as well.

TAX POLICY CONSIDERATIONS

The current income tax system makes the "price" of health insurance less than the price of other goods and services because employer contributions for health insurance premiums are excluded from employees' taxable income. Employer-provided health insurance, in effect, is purchased at a discount relative to goods and services bought from taxable wages and salaries. The appropriateness of this policy needs to be carefully examined.

In addition, the tax cap would have a progressive impact. The average tax benefit derived under current law is directly related to income—the higher one's income, the larger the tax subsidy for health benefits.

EXISTING COVERAGE

Companies and individuals should have the right to purchase health benefits as they see fit. The proposed limit on tax-exempt employer-provided health benefits, which would affect an estimated 30 percent of the population with employer-based coverage, would be set at a level that would permit complete subsidization of protection against the financial consequences of serious unpredictable illness. Individuals then could purchase additional coverage as desired.

Extensive private group health insurance coverage is readily available for about $2,100 per year or $175 monthly—the levels most commonly discussed in conjunction with a cap. Comprehensive health plans provided through the Federal Employees Health Benefits system are but one example of those within these limits that would not be affected by the cap. This coverage includes: full coverage with some copayment and deductible for inpatient hospital care, full coverage at reasonable and customary charge with some copayment and deductible for physician services, and some coverage for prescription drugs.

CONCLUSION

While the tax system should be designed to encourage to provide an adquate level of health benefits to their employees, it should not be openended. Individuals whose employer contribution exceeds a set limit could maintain their current insurance levels with after-tax dollars, but would not be encouraged to buy more insurance.

Excessive health benefits are inflationary and insulate all elements of the health care system from health care decisions, contributing to inefficient use of health care resources.

Reducing the rate of inflation in the health care sector requires addressing not only Medicare and Medicaid outlays but also private health spending. The limit on tax-free benefits would help address these issues without reducing an individual's opportunity for protection against the serious financial consequences of illness.

We look forward to working with the committee on this and other issues and I would be pleased to answer any questions you might have.

STATEMENT OF DR. WILLIAM FELTS, MEMBER, AMA COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, D.C.

Dr. FELTS. Thank you, Senator.

My name is William R. Felts. I am a physician in the practice of internal medicine and rheumatology in Washington, D.C., and I serve as a member of the American Medical Association's Council on Legislation.

Accompanying me is Christopher Damon of the AMA's Department of Federal Legislation.

The American Medical Association appreciates the opportunity to present testimony on the administration's proposal to place a limitation on the amount of employer-provide contributions for health insurance premiums that an employee may continue to receive tax-free, referred to as the "tax cap" approach.

The American Medical Association supports a limitation on the current unlimited tax-free status of employer-provided health insurance. This support is based primarily on the expectation that such a cap would increase consumer cost consciousness and thereby help to reduce the increases in health care costs.

A cap on tax-free health insurance benefits received by an employee could lead to a reexamination of expensive first-dollar coverage and could result in the offering of less expensive plans incorporating larger deductible or copayment amounts.

Studies and experience indicate that even modest deductibles and copayments can have a signficant impact on reducing inappropriate demand for health care services by increasing consumer cost-consciousness.

The tax cap proposal would assist in reducing overall health costs by restraining demand for health services, and it represents a preferable alternative to the regulation of the supply side of health services through central planning which ultimately leads to the rationing of health care.

The American Medical Association has developed principles for consumer-choice health insurance plans to modify the incentives that encourage expensive first-dollar coverage in employee health benefit plans. These principles are intended to stimulate competition, and a copy of them is attached to our statement.

The AMA has two concerns with the proposal. We recommend assurances that an enactment recognize future medical care cost increases, and we support incorporating an indexing provision based upon the medical care component of the Consumer Price Index that will adjust the cap to reflect future changes in medical costs.

We also urge employers, employees, and third party payors to adjust plans by increasing patient cost-sharing and by offering multiple plans with varying deductibles and levels of coinsurance. Plan costs should not be arbitrarily reduced simply by reducing the breadth of benefits provided by health insurance plans.

In conclusion, the American Medical Association supports the adoption of the President's tax cap proposal with the above discussed modifications. We believe that it represents an important first step in rationalizing economic decisionmaking by encouraging the offering of less expensive plans providing for greater individual responsibility and cost-sharing.

The existing incentive for overinsuring through Federal subsidy should be eliminated, and the administration's proposal as embodied in S. 640 is a reasonable and measured response addressing the problem.

We urge the committee to give favorable consideration to this proposal and provide for appropriate indexing of the tax cap level.

Thank you.

Senator PACKWOOD. Doctor, thank you.

[The prepared statement of William Felts follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, PRESENTED BY WILLIAM R. FELTS, M.D.

Mr. Chairman and Members of the Committee, my name is William R. Felts, M.D. I am a physician in the practice of internal medicine and rheumatology in Washington, D.C., and I serve as a member of the American Medical Association's Council on Legislation. Accompanying me is Christopher Damon of the AMA's Department of Federal Legislation.

The American Medical Association appreciates this opportunity to present testimony on the Administration's proposal to place a limitation on the amount of employer-provided contributions for health insurance premiums that an employee may continue to receive tax-free. This proposal has become known, in short-hand, as the "tax cap" proposal and for simplicity's sake I will occasionally use the phrase in referring to the proposal in this statement.

DESCRIPTION OF THE PROPOSAL

The specifics of the President's proposal are contained in S. 640, a bill introduced by you, Mr. Chairman, at the request of the Administration. S. 640 would provide that employer contributions to a health plan would be includible in gross income of the employee to the extent that they exceed $70 per month for an individual employee or $175 per month for family coverage. The amount of an employer's contribution would be determined (in the case of an insured plan) on the basis of the premiums charged for such insurance. Total premiums paid by the employer would be divided by the number of covered employees to determine the per-employee amount. If different plans are maintained covering different employees, each plan would be treated separately in determining employer costs per employee. Where an employer self-insures, the amount of the employer contribution will be based on estimated costs of providing coverage under the plan.

Only the excess over the "cap" would be includible in the employee's gross income and subject to taxation, not the entire contribution. If the contribution falls beneath the cap, then no income attributable to employer-paid insurance premiums would be includible by the employee. The proposal will generally be effective January 1, 1984, although there are exceptions to take into account employment contracts extending beyond that time. The proposal is estimated to raise revenues of $2.1 billion in FY84 and $31 billion over the next five years.

AMA SUPPORT

The American Medical Association supports a limitation on the current unlimited tax-free status of employer-provided health insurance. In fact, as an incentive to encourage individuals to avoid over-insurance, the AMA has supported the concept of such a limitation since 1978 when it adopted such a recommendation of the National Commission on the Cost of Medical Care.

Although in this time of large deficits many might view the tax cap proposal as desirable primarily from a revenue-enhancement point of view, our support is based on the expectation that such a cap would increase consumer cost-consciousness and thereby help to reduce the increases in health care costs.

A cap on the tax-free health insurance benefits received by an employee could lead to a re-examination of expensive first dollar coverage and could result in the offering of less-expensive plans incorporating larger deductible or copayment amounts. Studies, notably one conducted recently by the Rand Corporation, indicate that even modest deductibles and copayments can have a significant impact on reducing inappropriate demand for health care services by increasing consumer cost-consciousness. The AMA continues to support modifications to the tax code to modify the incentives that encourage expensive first dollar coverage in employee health benefit plans, and we have developed principles for consumer choice health insurance programs. The principles are intended to stimulate competition by providing the employee with multiple options for health insurance coverage and enabling the employee to make a prudent selection. A copy of these principles is attached to this statement.

The tax cap proposal would assist in reducing overall health costs by restraining demand for health services and it represents a preferable alternative to regulation of the supply of health services through "central planning" which ultimately leads to the rationing of health care.

Mr. Chairman, at a time when all of us are concerned about the increasing expenditures for health care, we feel that the tax cap proposal is an appropriate step toward removing one of the incentives to overinsure and overutilize services.

We believe that the levels for the cap found in the administration's proposal ($70 for a single employee—$175 for a family plan) would generally provide for an adequate health insurance policy. The cap would eliminate the incentive to increase health benefits that exists under current law since now the employee in effect receives a full dollar for every dollar paid by the employer for insurance premiums. If the employee took the dollar in salary, its benefit to him would be reduced if he had to pay tax and use the balance remaining to pay the insurance premium. While the purchase by the employer is not itself a problem, the resulting comprehensiveness coverage can stimulate excesses in the use of the health system. Under a tax cap, employees will be faced with a different tax consequence where additional benefits provided through an increased premium contribution will come from "after tax" dollars. In the final analysis, a "cap" can cause a close analysis of the need for a premium expenditure and can result in greater individual responsibility in the use of the health system.

AMA CONCERNS

The American Medical Association has two principal concerns with the tax cap proposal as introduced by the Administration (S. 640).

First, as presently drafted, the proposal contains no provision to recognize future increases in the cost of medical care and a concomitant increase in employer health plan costs. Although the cap at its proposed level has been estimated by the National Center for Health Service Statistics to affect only one-fourth of workers who have health insurance, the number affected could rise if the cost of plans increases while the cap amount remains at the level contained in the legislation.

To prevent this form of inflationary "bracket creep", we recommend that the legislation incorporate an indexing provision that will adjust the cap to reflect future changes in medical costs. In this way the cap will continue to discourage primarily only the very expensive first-dollar health plans but will not impose undue tax consequences on workers whose health plans become more expensive solely due to inflationary trends. We believe that the medical care component of the consumer price index is the appropriate index.

Our second concern focuses on the scope of benefits offered by the employer. We urge employers, employees, and third party payors to adjust plans by increasing patient cost-sharing and by offering multiple plans with varying deductibles and levels of co-insurance. Plan costs should not be arbitrarily reduced simply by reducing the breadth of benefits provided by health insurance plans. We believe that employer-based health insurance has proven to be an extremely successful mechanism for providing most Americans with access to comprehensive health care services and this feature of our health care system should not be weakened in order to maintain first dollar coverage with its demonstrated economic inefficiencies.

CONCLUSION

The American Medical Association supports the adoption of the President's tax cap proposal with modification. We believe that it represents an important first step in rationalizing economic decision-making by encouraging the offering of less expensive health plans providing for greater patient cost-sharing and individual responsibility. The existing incentive for overinsuring (through federal subsidy) should be eliminated and the Administration's proposal as embodied in S. 640, if modified, is a reasonable and measured response addressing the problem. We urge the Committee to give favorable consideration to this proposal and to provide for appropriate indexing of the tax cap level.

CONSUMER CHOICE PRINCIPLES

The nearly universal coverage of medical expenses by health insurance or Government health programs has insulated most Americans from consideration of the cost of medical services. It is said that this is partly responsible for the continuing rise in medical care costs. Government responses have usually imposed limits on the supply of medical services; it has been AMA policy that demand for services must be addressed. Thus competition and individual choice must be enhanced as alternatives to regulation.

The following principles should be considered as a whole. They spell out a policy for greater individual choice and for incentives for prudent behavior by individuals. While the principles may singly state appropriate policy, it is intended that all principles be considered in reviewing consumer choice/Competition legislation.

1. Employment-Based Health Insurance. The growth of employment-based group health insurance for employees and their families should continue to be encouraged through tax incentives.
2. Adequate Benefits. Each health insurance plan offered to employees should contain adequate benefits, including catastrophic coverage. Plans which do not have adequate benefits should not qualify for tax deduction as a business expense for the employer.
3. Multiple Choice of Plans. Health insurance plan options, with varying levels of coinsurance and deductibles, should be available to employees; accordingly employ-

ers, through tax incentives, should be encouraged (but not required) to offer employees a choice of several health insurance plans. Multiple options will better meet individual and family needs and encourage greater individual responsibility in utilization of medical care services.

4. Equal Contributions. Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee.

5. Limitation on Tax Deductibility of Excessive Health Insurance Premium. A limit should be placed on the amount of health insurance premiums paid by an employer that would be tax exempt income to the employee, as with life insurance. This amount should be high enough to provide for adequate benefits and should be adjusted for inflation.

In order to discourage over-insurance and "first-dollar coverage" which can cause increased demand for care, amounts paid by the employer in excess of the limit would be taxable income to employees.

6. Rebate to Employees. In order to stimulate prudent selection of health insurance by employees, employees may receive non-taxable rebates when choosing an insurance policy where the premium cost is less than the amount of the employer contribution.

7. Quality of Care. Employer health insurance plans should assure employees the free choice of sources of medical care services. Services should be of high quality. Plans should provide comparable benefits for treatment of physical and mental illness.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, D.C.

Mr. Goldbeck. Thank you.

My name is Willis Goldbeck, the president of the Washington Business Group on Health.

As you might expect, very few management or labor leaders will support a tax on any fringe benefits. And in that context, we also oppose S. 640.

There are some significant additional problems rather than just the philosophical one. The bill would attack the expanded use of medical departments as a loophole, rather than recognizing the significant positive impact it could have on competition.

The growth of section 125 medical expense accounts would be significantly stifled.

Unless the tax status of cafeteria plans is cleared up favorably, they, too, would be stifled.

The health-enhancing and cost-reducing benefits referred to earlier as prevention programs would definitely be reduced. I might add that a typical example of that would be the health check program in Oregon.

One can't help but note the irony of the impact of health care costs on employers as a result of the medicare secondary payor legislation recently enacted by Congress.

I think you can ask whether or not costs will be significantly cut. We do not see any major reduction in health care costs at least during the first 5 years after such a tax cap, and in fact there may very well be an increase. The reaction of many employees quite typically and logically could be, "If we are going to be taxed on it, let's use it."

Six to twelve years later, three to four contract cycles, perhaps there would begin to be an impact. But that's an impact that's just one more stimulus—and a rather late one—to trends that are already well underway.

And I would note that the bill has absolutely no method of prohibiting the purchase of any kind of individual gap coverage.

Therefore, the persons who have lost some of their protection through the reduction of employment coverage could pick up additional coverage on the outside and remain fully covered, should they desire to do so.

From an equity standpoint it would be very hard to argue against reducing inequities in the Tax Code. This bill does not do that. It simply trades one inequity for another.

Consider the individual firm with half its employees unionized. They get to wait 3 years before the tax impact; the other half have the privilege of being taxed immediately.

Or those whose health status leaves them no choice but the high option plan—an option plan the cost of which will be going up dramatically the more there is a stimulus from the tax cap to have other people select lower option plans. And that directly addresses the question of age that has been raised several times today.

If you chose to go ahead with this, then we have several recommendations:

One is that medical departments not be included in any way in the computation. They are not compensation, they are not in health plans, they are not in benefits. They do respond to Government mandates, and they are procompetitive.

There should be an exemption for prevention programs. It is consistent with the entire thrust and objective of this legislation. They are not normally in health plans. They are not normally insured. They are procompetitive.

If you want a tax in this area, tax only that aspect of medical care, the utilization of which you want to reduce; that is, unnecessary hospital inpatient care and physician services.

All workers, including all Government workers, should be included.

The discrimination that has been referred to is a hypothetical discrimination. There is absolutely no way to tell in advance the degree to which that kind of discrimination will take place. The concern is obviously legitimate. Therefore it seems that one approach might very well be to establish a discrimination review panel from the outset to monitor the impacts on all the subsets of the population for which you have concern.

Let me conclude my remarks by noting that the tax cap, basically, would stimulate a little bit more of a lot of what is already going on today. It really is not needed.

Ten years ago the tax cap could very well have moved a lethargic employer community into reducing the amount of energy that has taken 10 years into perhaps a 3- to 4-year period. It would have been a positive impact, even if not necessarily a supported policy.

Today that is not where we are. We are far in advance of that. We have the capacity, and we have the progress underway, to make the changes that the tax cap says it wants to stimulate. If they were not already underway, there would be a much stronger argument for the cap.

I can't help but note that many who are in favor of the tax cap are the same people who are opposed to any of the other forms of controlling health care costs, such as funding the congressionally established professional review organization program that came out of this committee, or establishing a new health planning program. And, it is revealing indeed to hear the reference to not regulating the supply side so that the demand side can be regulated. I am reminded of the degree to which the supply side objected strenuously to any revenue cap, and now find the tax cap infinitely more attractive.

Thank you very much.

Senator PACKWOOD. Thank you.

[The prepared statement of Willis Goldbeck follows:]

STATEMENT BY WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

My name is Willis Goldbeck, President of the Washington Business Group on Health, a membership organization of major employers with a great stake in all aspects of our nation's health policy decisions.

Our members oppose the taxation of fringe benefits and thus also oppose the proposed tax increase for their employees who receive employer contributions for health care plans above the federally established maximum ($2,100 per year for a family and $840 per year for an individual).

Let me assure you that we do not come to this position casually or with callous disregard for the rate of cost escalation. Nor should our position indicate that the employer community is of one mind on this issue. There are growing numbers of companies and benefit managers who have become convinced that the tax cap would be of assistance in the cost management struggle.

Nonetheless, I'm sure you appreciate that few management or labor leaders will support the taxation of any fringe benefits, or the intrusion of government into the collective bargaining process. It is for these reasons, far more than a formal rejection of the potential health cost impact of the tax cap, that our members cannot accept this proposal.

In addition to the overall opposition I just expressed, our members have several general problems with the proposal.

1. There appears to be confusion among the cap supporters as to its real value and purpose.

A. If it is tax policy for revenue generating reasons, it is not effectively designed to maximize that objective.

B. If your objective is to change the economic incentives now stimulating wasteful and unnecessary medical care utilization by creating greater consumer cost consciousness and a more competitive marketplace, then the Administration's concerns are seriously flawed.

(1) Expanded use of corporate medical departments, which should be viewed as a positive new competitive force but rather as a tax loophole to be closed.

(2) The growing use of Sec. 125 medical expense accounts, which do create more cost awareness and competition, would be virtually eliminated for all but those plans which are well below the cap levels.

(3) HMOs and other prepaid or negotiated arrangements, the very essence of market forces, would be at a disadvantage if they offered the comprehensive benefits which the same government initially mandated and which are a primary reason for their market penetration.

(4) The IRS would make a greater contribution to competition if it would favorably resolve the tax status of cafeteria plans rather than imposing a cap that would stifle their development.

C. If the objective is to create a more equitable distribution of tax subsidies for health and medical care, then this laudable goal is contradicted, at least in spirit, by the array of blatant inequities the proposed cap would create.

2. Will the cap cut costs? In the short run (1-5 years) we believe there would be very little reduction and possibly an unanticipated increase as employees who, for the first time, are being made partners in private sector cost management strategies, would now be encouraged to adopt the attitude that, "If we are going to be taxed for it, we might as well use it."

In the long run (6-12 years), it is hard to deny that the tax cap, if strictly enforced, will have an impact. In straw polls, many benefit managers who doubt immediate impact tend to agree that the impact will be felt in two-to-four contract cycles. The pressure of rising costs; the long lead time for private control mechanisms to break down the institutional barriers to change; bankrupt government programs that will inevitably exacerbate cost shifting; an increasingly informed aggregate and individual consumer; and population demographics all suggest that a cap could stimulate more cost-effective plan design and consumer choice. One sign of this is the 1983 Steel Agreement which contains specific provisions, should a tax cap become law, to begin changing benefits to "reduce the amount of imputed income otherwise attributed to employees". However, the same factors are now producing change without the tax cap.

There is another aspect of the cost management question that has not received adequate attention. For the past four decades this nation has misspent its health care resources with some 94% being devoted to medical care and medical research. Considering what we know today about the relative impact on health status of medical care vs. lifestyle and prevention, it would be the cruelest of hoaxes to posture as concerned for costs while passing tax legislation that would reinforce this imbalance. The tax cap, to the extent that it is successful, would do just that. Employers and unions are not going to make major reductions in hospital coverage. But, they will reduce their commitment to preventive services . . . the less culturally entrenched benefits.

A basic premise of the cap is to end the trend for comprehensive insurance. In fact, many employers and unions are years ahead, having already made major expansions in deductibles, co-insurance, co-payments, alternative delivery system investment, negotiated agreements, employee/consumer prudent user education, and multiple choice options. Traditional insurance, for most large employers, is a dead issue. Various forms of self-funding are in vogue. New data systems which marry billing information with clinical information (such as DRGs) will foster this movement. Instead of struggling over the details of a tax cap which will cause more adverse selection, we should be working together to design the mechanism to finance and deliver care to those who increasingly will be left uncovered due to the prohibitive pricing of their only option, the high (option) cost plan.

Finally, we have no idea what, if any, the added costs will be due to those who delay care that is needed due to new cost pressures resulting from the cap.

3. What is a "health plan"? Terminology in the Administration's proposal needs to be clarified. Employer opposition is significantly increased as the proposal becomes more complex. The foremost example is the suggestion that the cost of medical departments will be included in the plan cost computation. To do so would contradict the basic concepts of the proposal itself:

A. Medical departments are not part of compensation.

B. Medical departments may be beneficial to some, but are not a corporate negotiated benefit.

C. Medical departments are not part of the health plan.

D. The few exceptions to C, such as Gillette, are furthering the identical competition and cost management goals that the tax cap proponents expouse.

E. Many medical department functions are the result of government mandates, not excessive benefit plans. The mandates may well be appropriate; a tax cap on them would not.

4. Who is covered? The Administration's proposal calls for two categories of covered persons, individuals, and family. However, large employers rarely use just those two categories. The variations are too numerous for a tax cap bill to define. However, there is no reason why the legislation could not allow an employer to use any categories it wishes, as long as the value of the employer contribution does not exceed the $2,100/$840 limits.

5. Supreme Court rules that employer contributions to trust funds for health and welfare are not wages. In *Morrison-Knudsen Co.,* v. *Director, Office of Workers' Compensation Program (DOL)* Sp Ct. 8-1, May 24, 1983, it was determined that "employer contributions to union trust funds for health and welfare * * * are not wages". This overturned *Hilyer* v. *Morrison-Knudsen,* 670 F. 2nd 208 (D.C. Cir 1981). The implication of the proposed tax cap would appear to be that, either the concept would violate the Supreme Court's new ruling, or the way to avoid the cap is to place all health benefit contributions in union trust.

6. Differential tax impact. Not only would employees with the same employer and plan be taxed very differently depending on where they live, or the average age of the members in their health plan, or the sex of their plan members, but also based on the date of their union contract. The latter seems especially troublesome. In a company with 50,000 union workers who have two years to go on a contract and 50,000 non-union workers with the same benefits, only those who are non-union would be taxed during the two years.

RECOMMENDATIONS

While we hope the tax cap will not become law, we would also like to offer a few recommendations that would make such a cap less negative.

1. Do not include any medical department costs within the cap computation. If Treasury insists in pursuing this misguided approach, then at least delay its implementation for three years after the cap begins. This will give management and labor a chance to build the administrative capability to implement the basic cap on "plan" contributions. Equally important, Congress will have time to assess the cap's impact on the use of medical departments. If the result is positive, then there will be no need to include them within the cap limit. If problems do arise, then Congress will know to what purpose the inclusion is being designed and employers will be able to cope with the administrative issue because the basic plan will already be in place.

2. Exempt a defined group of prevention services. Congress has every economic and health reason to encourage the growth of prevention services. Left out of the cap limit, they will grow and continue to reduce otherwise unnecessary hospitalization while helping to achieve improved health status. I am not suggesting that every item that any provider declares to be of a preventive nature be included on the exempt list. Specifically, I am referring to the worksite wellness programs which are not part of the regular health "plan", although they do fall within the IRS Sec. 213(e) definition of "medical care". These are not insured, nor are they normally included in actuarial estimates of per-employee plan costs. Therefore, such an exemption would not be a change but rather a continuation of current practice. If you are going to pass the tax cap, at least seize the moment to have this Congress be the first in U.S. history to back up the rhetoric of support for prevention with the reality of a legislative commitment. Not only would this be a valuable symbol, but also the growth of these programs would occur at no new cost to the government.

3. All workers should be included. If you are concerned for cost management outcomes like employee choice, and if you want to raise revenues, and if you want to lessen the tax subsidy gap between poor and non-poor, then there can be no justification for exempting millions of government workers.

4. Discrimination review. With good reason, there is concern that the cap would result in employment discrimination against older persons, women, handicapped, and those for whom pre-employment screening indicates the likelihood of high medical care utilization. Since there is no way to confirm or deny this in advance, and since the problem could have grave consequences, we recommend the establishment of a Discrimination Review panel with the resources to monitor the tax cap's implementation and its impact on employment. The panel would be obligated to report simultaneously to the Department of Labor and the Congress, annually. The panel would be comprised of public and private members representing labor, management, the handicapped, etc., and should be chaired by an ethicist or someone with comparable skills who is not affilitated with any of the parties of interest.

5. UB-82. With the passage of every regulatory measure, such as prospective pricing or the tax cap, the need to speed up implementation of UB-82 becomes more compelling. How ironic that hospitals which should be able to implement UB-82 in almost no time (after all, it contains more than information which should have always been provided) are given years to "get ready" while employers will be asked to adjust administratively to the tax cap—a far more complex and costly requirement—in a fraction of the time.

6. Full disclosure requirement. Employers and unions are at a disadvantage when trying to manage their utilization—thus their costs—due to the absence of quality-of-care and financial data that would enable institution and physician-specific comparisons. The tax cap is predicated on the assumption that employers and unions will be able to manage their plans at a level below the cap. To support this essential assumption, the Congress should add to the legislation a full disclosure requirement thus assuring all private sector purchasers access to the same data which you have already identified as being vital for the management of Medicare. No providers should be exempt. If the consumer is to be encouraged by tax policy to shop for the most cost-effective care, then government incurs the obligation to guarantee a free flow of information upon which meaningful choice can be based. There is no such thing as a competitive market when the consumer is denied such information.

CONCLUSION

Let me reiterate that most employers remain opposed to the cap. Even the growing number of supporters come to their position out of a desperation born of years of cost increases that cannot be explained, in a system that resists every attempt at rational public accountability and defies the economics that normally govern other businesses.

The cap has been characterized as impossible to administrate. This is not true. Difficult, yes; costly, yes; but well within our capability.

The cap has been characterized as a threat to quality care and even access to needed care. This is not true. A new financial burden at a bad time in the national economy, yes; new pressures to make complex choices, yes; but not even the most highly taxed will be financially threatened or be forced to abandon appropriate medical care.

The cap has been characterized as the alternative to rate-setting or revenue caps for providers (thus their support). This is not true. In fact, employers and unions, faced with substantial benefit cuts or the wrath of newly taxed employees, will have new incentive to lobby together for strong state rate-setting, hospital construction moritoria and physician fee schedules.

The cap has been characterized as the centerpiece of the market forces or consumer choice movement. This is not true. Market forces have been steadily increasing for the past five years, with no tax cap. The cap is designed to hit a very small percentage of the nation's employees (approximately 15 percent) thus clearly not stimulating sweeping changes in cost awareness, consumer choice or provider behavior. Competition will continue to increase because of physician oversupply and overspecialization, because of waste and excess capacity, because of TEFRA, because of an aroused and increasingly informed purchaser community, and yes, because consumers will be exercising greater choices as the alternatives become economically attractive to offer. The cap will enhance this movement, but too marginally to warrant support.

In the final analysis, the cap is behind the times. All the good things it's supposed to do for health policy and thus cost management are already well along in development. By the time it would have a serious impact, 6–12 years from now, we will have seen either considerable success or a governmentally-imposed system restructuring. Ten years ago, the cap would have jolted a lethargic purchaser community, sent a caution to expansionist-oriented providers, led to a restructuring of the insurance industry, and increased public cost consciousness. With the cap ten years ago, we could have squeezed ten years' work into three or four. But today, we have neither the need nor the luxury of retreating ten years. Today, we must look ahead to the critical issues: access for those denied; the ethical dilemmas of rationing technology; environmental and workplace public health hazards of a magnitude never contemplated in all of history; management of miracles . . . genetic engineering, cancer remission by visualization, and space pharmacology, to name just a few; capital generation for the care-giving system's physical plants; the re-education of a public still raised on the myths that doctor always knows best, the hospital is always good, insured care is free care, fancy=better, and we are supposedly too ignorant to assume major responsibility for our bodies—ourselves.

In the next few years, we need to devote all our energy to the management and evaluation of the changes taking place, not to the administrative complexities of a tax cap, the purpose of which is to do what is already happening. Nor can we support a tax cap that is advocated by those who decry cost escalation, yet lack the will to support compatible regulation of providers through such vehicles as a well-funded PRO program and a newly-authorized, revised, planning program. The same Congress and Administration that created TEFRA and prospective pricing, and proposed the tax cap, cannot claim that other helpful programs are fatally flawed by the very nature of being regulatory.

Let us build on the progress of the last ten years by seeking a balance between competition and regulation and by squarely facing the financially and ethically challenging issues ahead. The tax cap is not the solution.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, WASHINGTON, D.C.

Mr. BROMBERG. Thank you, Mr. Chairman.

I am Mike Bromberg, executive director of the Federation of American Hospitals, and I will try to be brief.

Our major point is that our present system of taxation as well as health care financing, taken together, has desensitized providers and consumers to the true cost of health care through the extensive use of first-dollar coverage and a low copayment rate. It has also done it through hidden subsidies such as the Federal tax cap, which is basically a $29 billion subsidy which very few people know about, of private insurance, by the Government, and I'm sure that very few of your constituents realize that there is such a direct subsidy.

Restoring cost-consciousness to providers and consumers is an essential part of any solution to the health cost problem. Without it the demand is infinite, and that's why we urge you to enact solutions which do address the demand side.

I would like to read just one or two paragraphs of the testimony we have submitted, starting on page 7, because it comes from a report I found fascinating. It is a quote from the President's Commission for the Study of Ethical Problems in Medicine, their volume called Securing Access to Health Care and this is the report written by Morris Abrams as chairman for that commission. I think it contains some rather sound advice on health care policy.

With reference to the tax-free treatment of employer-purchased insurance, the Commission stated:

> The employer exclusion provision gives a larger subsidy to those with a smaller need for financial protection and exacerbates the tendency of lower-income people to be less well insured than those with higher incomes.

The Commission also said:

> This pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care * * * without undue hardship.

The fringe benefit of health insurance and its open-ended tax subsidy, now estimated, as I said, at about $29 billion for next year, represents substantially, in fact, more than 50 percent more than the Federal Government is now spending on medicaid, a program which is supposed to help people who can't afford it.

Since there is no limit on this exclusion, neither side, labor, management, or anyone else, has any great financial incentive to reduce benefits, reshape benefits, enter preferred provider arrangements, or provide less than first-dollar coverage. It effectively eliminates any cost-consciousness on the part of consumers as well as providers of care.

Now, we have just tried to bring some price competition to hospitals through the enactment of a landmark medicare prospective-payment system. Now we need to send that same message to everyone else in the system, including the insurance industry. And we must give employers and employees the incentive to be cost-conscious in their purchase of insurance plans and the designs of those plans.

We must all share in the responsibility for using our health care resources prudently. Capping the open-ended tax preference will give employers and employees an incentive to shop for more cost-effective plans and providers, and to become more directly involved in utilization-review decisions.

Even if everything possible is done to improve productivity, even if you put controls on providers, the odds are that revenues will still one day soon fall short of the money needed to meet the legitimate health care needs of the elderly, the poor, and others.

A recent American Hospital Association study on care for the poor is quoted in our testimony, and says, basically, "Once documented, the problem of hospital financial stress becomes obvious. A hospital cannot provide service without compensation and remain financially viable." That relates to hospitals with high charity loads.

The implication of that is that the haves, one way or another, have to help the have-nots in order to have adequate health care financing. And the question is: How?

The President's Ethics Commission felt that a tax cap on private insurance met that test of equity because it spread it across the whole population, particularly those who can afford it, those who are working, most of whom have incomes of over $30,000 a year.

The open-ended subsidy should be closed, so that some of that revenue—if we do get that $2.5 billion the first year and $30 billion over 5 years—can be used to save the medicare trust fund or to subsidize health insurance for the unemployed.

Thank you, Mr. Chairman.

[The prepared statement of Michael Bromberg follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR OF FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman and Members of the Committee, my name is Michael D. Bromberg, Executive Director of the Federation of American Hospitals.

The Federation of American Hospitals is the national association of investor-owned hospitals and hospital management companies, representing 1,045 hospitals with over 120,000 beds in the U.S. alone. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent more than 20 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to appear before you to present our views on the Administration's proposal to place a limit on the tax-exempt amount an employer can contribute to an employee's health plan. These hearings come at a very important and appropriate time. Congress has just enacted the most significant change in Medicare hospital reimbursement since the inception of the Medicare program by establishing a prospective payment system. Although prospective payment is an important first step, it alone will not solve the problem of health care inflation, and the impending insolvency of the Medicare Trust Fund.

INCREASED DEMAND

Because the proportion of the population over 65 will increase markedly over the next decade, the utilization of health care services per capita is expected to increase dramatically, Medicare expenditures, even after being adjusted for inflation, are expected to increase by 60 percent over the next five years.

Among the major contributing factors to hospital cost increases are admissions and intensity. The cost of treating over age 65 patients generally is more than two times the cost of treating patients under age 65 in hospitals. The following chart illustrates the admission intensity trend:

PERCENTAGE INCREASE IN ADMISSIONS

	1978	1979	1980	1981	1982
Under age 65	1.0	1.7	1.5	0.0	−1.6
Age 65 and older	4.9	5.3	6.7	3.0	4.1

The intensity area also includes technological advances which save and prolong lives and are costly. There are many social, ethical and economic questions which can be raised in this area, but an aging society requires more intensive health care.

During the past twelve months admissions of over age 65 patients rose more than four percent while the rate of under age 65 admissions declined. Demand is the single most serious aspect of hospital cost increases and until demand is addressed, there will be no solution to health care inflation.

The government's commitment to the elderly, however, needs to be restated in terms which assure the elderly that their health benefits will be paid from a financially stable trust fund. It should also be made very clear to beneficiaries and providers that the government's commitment to pay for covered services does not mean there is no budgetary limit on the quantity of services that may be consumed. Until we address this issue, there will be no real solution to the increasing pressures on the Medicare Trust Fund.

A MARKET STRATEGY

The large body of studies examining the cause of health care expenditure growth all point to the same conclusion: the problem is not inefficiency but utilization—patients, freed from the burden of payment, demand more; and physicians and hospitals, unrestrained by cost-based reimbursement, provide more.

Our present system of health care financing has desensitized providers and consumers to the true cost of health care through the extensive use of first-dollar coverage and low copayment rates. The situation has been aggravated by cost reimbursement which encourages excessive spending. The result is intense quality competition but little price competition.

Restoring cost consciousness to providers and consumers is intrinsic to any solution to rising health costs. Without price awareness, demand for health services is infinite. That is why we urge you to enact solutions which address the demand side of the problem.

This Administration, like others before it, recognized that cost reimbursement has fueled health expenditure increases and needed to be replaced. Congress agreed and recently enacted a system which turns around the incentives in order to reward management efficiency and restrain utilization. We were supportive of the Medicare DRG pricing which becomes effective on October 1. However, that one long overdue change will not solve the health cost problem. We urge you to accelerate efforts to bring marketplace competition and restraints on utilization to the system by supporting a ceiling on tax-free employer-purchased health benefits, designed to encourage the offering of cost-effective insurance plans.

A large body of economic analysis strongly supports the conclusion that financial incentives have a significant impact on utilization. Utilization goes down as cost sharing goes up. Here is a typical finding:

". . . when compared with full coverage, a 25-percent copayment reduces utilization and expenditures by 20 percent." (Charles E. Phelps, "Health Care Costs, The Consequences of Increased Cost Sharing," Rand Corporation, Santa Monica, California, November 1982.)

Congress, upon enactment of Medicare and Medicaid eighteen years ago and until quite recently, perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision, combined with a cost-based reimbursement mechanism which rewards spending and penalizes efficiency, triggered the demand-pull inflation contributing to the inflation in the health care expenditures. The recently enacted Medicare prospective pricing system is a long overdue step to correct the disincentives of that federal program.

The hospital industry has simultaneously been hit with severe cost-push inflationary pressures for the past ten years. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel, and malpractice insurance; rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; increased capital cost; and increased cost of compliance with government regulations.

Many industries have faced similar cost-push inflation pressures, but none have experienced simultaneously the increased demand for services similar to that triggered with enactment of the Medicare and Medicaid programs using inflationary cost-based retroactive reimbursement payments for hospital services.

Even without general inflation, federal and state health expenditures will still grow faster than tax revenues. For example, had there been no inflation over the period from 1977 through 1980, health expenditures would still have grown 14 percent in real terms. Of this amount, about 37 percent would have been due to population growth and 63 percent due to higher utilization per capita.

Since inflation can be dealt with effectively only by appropriate fiscal and monetary policy, health policy—to have the maximum beneficial impact—should focus on the next most important problem—utilization.

The decisions regarding health policy boil down to who should benefit, who should choose, and on what basis the choices should be made. Ideally, the beneficiaires should be both the individual patient and society as a whole. The choice as to the use of health care services should be in the hands of patients and their physicians. And, the basis of choice should be a combination of the best health interests of patients and society's interest that the extra value provided by extra services equals or exceeds the extra cost.

The President's Commission for the Study of Ethical Problems in Medicine has published a volume on "Securing Access to Health Care," which provides some sound advice on how government should establish its priorities in health expenditures.

With reference to the tax-free treatment of employer-purchased health insurance to employees, the Commission noted:

"The employer-exclusion provision gives a larger subsidy to those with a smaller need for financial protection and exacerbates the tendency of lower-income people to be less well insured than those with higher incomes." The Commission goes on to say that "this pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care * * * without undue hardship."

We heartily endorse this position and believe that on fairness grounds alone the tax cap should be applied forthwith.

The tax subsidy, now estimated at about $29 billion, represents substantially more than the federal government spends on Medicaid.

TAX POLICY

Current tax policies devised to stimulate certain behavior often prevent the efficient delivery of quality health care. Financing of health care through income exclusions and deductions often results in apparent misallocation of health resources, while other Internal Revenue Code provisions and regulations prevent arrangements leading to more efficient use of those resources.

Many view the exclusion from employees' income of the employer contribution for employees' health insurance as a major factor in rising health care expenditures. The "Health Cost Containment Tax Act of 1983," S. 640, introduced by Senator Dole, deals directly with the employer contribution issue and focuses on tax laws as a potential catalyst for health care system reform. Current tax subsidies, over $29 billion in value, fuel the demand for insurance, utilization, and unrestrained spending in the health field.

EMPLOYER CONTRIBUTION EXCLUSION

Presently, under Section 106 of the Internal Revenue Code, amounts contributed by employers for employees' health insurance are not included in the employee's income. This amount also is not included in the amount of the employee's pay which is subject to Social Security taxes. Consequently, employees have a great financial incentive to bargain for more costly, broad, employer-financed health benefit packages. Since there is no limit on the amount of the exclusion, neither side—labor nor management—has any great financial incentive to reduce health benefits, participate in preferred provider arrangements, or provide less than first-dollar coverage. Employees are not encouraged to seek benefit packages more specifically tailored to meet their health care needs, especially in light of the prevalance of group health coverage. Such broad coverage stimulates more frequent utilization of health care services and drives up health care expenditures. It effectively eliminates any cost consciousness on the part of consumers of health care.

Enactment of a ceiling on the employer exclusion would cause many employers to voluntarily offer multiple health plans including a low-cost option.

Eliminating the open-ended employer contribution while encouraging equal contributions to all employee health insurance plans will stimulate competition among health plans and providers. Also, consumers of health care must have some financial stake in the system through some cost sharing of premiums and copayment of incurred costs in order to bring some market-oriented restraint into decisions about utilization and choice of plans. Higher premium and delivery costs should be borne by the party selecting the plan or provider.

Just as we have brought price competition to hospitals through enactment of Medicare prospective payment for hospitals, we need to bring price competition to the insurance industry. We must, however, give employers and employees the incentive to be cost conscious in their purchase of health insurance plans.

Hospitals cannot be held solely responsible as the reason for increasing health care costs. We must all share in the responsibility of using our health care resources prudently and efficiently. Capping the open-ended tax preference for employer-paid health insurance will give employers and employees an incentive to shop for more cost-effective insurance plans and providers and to become more directly involved in utilization decisions.

We have finite government resources available for health care and must examine how these resources can best be allocated.

Even if everything possible were done to improve productivity, the odds are that revenues would still fall short of the money required to meet legitimate health care needs. As a recent American Hospital Association study on care for the poor noted:

"The best indicator of fiscal stress is not some measure of efficiency, management initiative, or occupancy, but instead, a hospital's volume of care to the poor.

"Once documented, the problem of hospital financial stress becomes obvious—a hospital cannot provide service without compensation and remain financially viable."

The implication of this finding is that the haves, one way or another, should help finance adequate care for the have-nots. The question is not whether, but how.

A tax cap on private insurance, with revenues earmarked for the Medicare and Medicaid programs, would meet that ethical test.

The open-ended federal subsidy for private insurance should be closed in order to free needed revenues for those unable to finance their own care, and government should be a prudent purchaser of adequate care even if recipients have more limited choice of providers.

We urge Congress to address broader health policy issues by bringing marketplace competition to and restraints on utilization of our health care system by enacting a ceiling on tax-free employer-purchased health benefits.

This change in conjunction with the Medicare hospital prospective payment system will help achieve a more rational health policy.

We thank the Chairman and the Committee for this opportunity to express our views on limiting the tax deductibility of employer-paid health insurance premiums.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. Mr. Epstein, on the average, what is your occupancy rate in the hospitals your association represents?

Mr. EPSTEIN. That would vary across the Nation. I don't know that the figure is useful. And it also changes from week to week and from month to month and season to season.

Senator PACKWOOD. So you have no average figure?

Mr. EPSTEIN. Probably somewhere between 70 and 75 percent.

Senator PACKWOOD. Now, why wouldn't your costs go down if you were running at 90 or 95 percent occupancy, or at least your per-unit cost?

Mr. EPSTEIN. Per-unit costs go down?

Senator PACKWOOD. Yes.

Mr. EPSTEIN. With respect to some services, no doubt they would.

Senator PACKWOOD. It seems to me you've got an underutilized capacity, as do many industries in this country. You are not unique; unfortunately we are underutilized in many areas. But I don't see how this bill is going to bring down hospital costs if the effect of it is to cause slightly fewer people to use hospital services than they might otherwise use them and drive down your occupancy rates even lower.

Mr. EPSTEIN. What the Senator is addressing is the larger issue of whether or not lessening utilization would contribute to the need to lessen the escalation in the increase of costs.

Senator PACKWOOD. I want to know how it reduces hospital costs.

Mr. EPSTEIN. Hospital costs. Yes. I don't think there is any question but that it would, and I think that's why we are all jointly undertaking to reduce utilization, to address issues of utilization.

Senator PACKWOOD. Well, why would it reduce your costs if your occupancy drops from 75 to 65 percent because of this bill?

Mr. EPSTEIN. You are assuming in the question a system of exactly the same size.

Senator PACKWOOD. Pardon me.

Mr. EPSTEIN. I say the question that is being put assumes a system that is exactly the same size.

Senator PACKWOOD. What do you mean, "a system"?

Mr. EPSTEIN. A system of hospital care, of institutional care.

Senator PACKWOOD. Do you mean my question presumes all the hospitals are the same size?

Mr. EPSTEIN. No; that it would remain the same size that it is and that the capacity would remain the same.

The neat thing that is going on now, with the pressures that are being put on the issue of costs, the neat thing is that alternative delivery systems are coming into place.

You are familiar, of course, with ambulatory care as an alternative system, outpatient care, care that is given outside the more expensive chassis represented by the hospital. Now, that has an effect, obviously, on the hospital building. It may mean that as the Hill-Burton hospitals are wearing down they don't need to be replaced with as many beds or with as many facilities. And this can be allowed to happen as we move care out to less-expensive locations in order to render it.

That's why I say the question assumes that the system would remain as it is, and I don't foresee that it will.

Senator PACKWOOD. Mr. Epstein, do you know if there is an internal memorandum in the American Hospital Association in the month of April suggesting that the administration is going to become frustrated by medical costs, and if they cannot find an answer they will return to the hospital cost-containment program, and the memo uses the expression "it's better us than them," and therefore you have come to the conclusion to support this program to shift away from the possibility of hospital cost-containment? Do you know of any such memo?

Mr. EPSTEIN. No; I don't.

Senator PACKWOOD. Were there any discussions within the American Hospital Association at all about the possibility of hospital cost-containment if this was not adopted?

Mr. EPSTEIN. If which was not adopted?

Senator PACKWOOD. If the administration's cap or some other effort at restraining medical costs.

Mr. EPSTEIN. Well, very clearly, very clearly and this has been shared publicly and it was part of our testimony, and it was the reason for the very active and visible role of the American Hospital Association in support of and in the fashioning of the prospective payment proposal that there needed, Senator, to be a solution to the escalation of costs. And it was going to happen either of two ways—it was either going to happen by imposing a regulatory system on hospitals, or it was going to happen by changing the incentives. And I don't think there is any question about acknowledging that choice.

Senator **Packwood**. You know of no memorandum that I made reference to?

Mr. **Epstein**. No; but I would be glad to inquire further about it.

Senator **Packwood**. I think you should.

I have no other questions right now.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. Thank you, Mr. Chairman.

Perhaps, without positing a question, I might try to clarify what hasn't come through too clearly from the administration witnesses.

This particular piece of legislation is not a be-all and end-all. This piece of legislation is not going to answer all of the questions that were posed in terms of what is the problem and what is the solution.

But if you look at the problem as the high cost of health care, and you look at the solution in terms of the sensitivity of consumers of health care to the costs of getting sick, and the incentives for staying healthy and buying smartly, then the answer to the question just posed to Mr. Epstein by Bob Packwood is that this proposal—in and of itself—isn't going to provide any kind of dramatic changes. But this proposal, in combination with all the other things that are happening out there, starts to do things like the AMA has outlined in their set of principles. Hospitals will react the same way that they react to other forms of smart buyers. They will try to get efficiencies into the system.

Then other people out there who think they can do it better than the existing hospitals come on the scene and say, "Hey, we can do freestanding surgery; we can provide ambulatory care; we can do all these things you are doing in the hospital for a lot less money."

If that happened, some of those hospitals would go out of business. The ones that can't make it in a price-sensitive market disappear.

Mr. **Epstein**. Or the hospitals go into those businesses.

Senator **Durenberger**. Thank you, Mr. Chairman.

The **Chairman**. Senator Long.

Senator **Long**. You might want to conclude what you were saying, Mr. Epstein. You didn't have the opportunity to make a full statement. During my 5 minutes I would be happy to have you amplify what you were saying, if you want to add to it.

Mr. **Epstein**. I appreciate that, Senator Long.

First, just to finish this thought, in moving utilization out of the hospital, it does not mean that the hospital necessarily closes. It changes its form of business and there are a variety of ways of doing that.

In the discussion this morning it sounded as though there was a threat to the provision for health insurance coverage, that persons would be deprived of that kind of protection. And as that discussion went on, I think we lost sight of the real impact of this proposal: It is not to put a limitation on benefits; it is simply a matter of saying, in effect, as a hypothetical, that at $170 or $175 the value of a health insurance program beyond that becomes taxable income. So that we are then looking at what would be the tax impact on an individual employee in that hypothetical of $25 a month.

We are not talking about any interference with the benefits that are available to that employee.

The other thing that came up was whether or not certain kinds of groups would be discriminated against or how they would be affected in various parts of the country—either by age or by income or by danger, which was another question that was put.

Interestingly, that goes around and really ignores the basis on which you start, and that is that health insurance from one employer to another, from one place to another, from one industry to another, is not uniform across the Nation.

And I didn't quite understand the quest for uniformity of impact here when we are talking about this add-on, when we don't even look for, seek, and I suppose even find desirable a notion of uniform health coverage to begin with. And I think we lost sight of that in the discussion.

Those were just a couple of the points. Thank you very much, Senator Long.

Senator LONG. Thank you for your statement. Thank all of you for your statements. I enjoyed them. You made good statements today.

The CHAIRMAN. This is a very good panel. And I think we are going to have to focus on this issue, whether we like to or not. I think we are going to have to make some changes, and we are trying to do it in the right way.

There have been some good ideas expressed here. At least we are going to try to do it in the right way, and hopefully that will happen, but that depends on the will of the members of the committee.

But again, getting back to my original statement, if in fact the budget resolution passes it is really going to put the pressure on this committee to do a lot of things we might rather avoid.

As I understand, Dr. Goldbeck, from your statement, you believe that the tax cap would decrease the growth of special employer-sponsored prevention programs such as nonsmoking programs. Is that correct?

Mr. GOLDBECK. Yes, sir. And for the record, I'm the nondoctor.

The CHAIRMAN. Oh, excuse me.

Mr. GOLDBECK. Yes, we do feel that. I noted Dr. Rubin's comments, and he is certainly correct that obviously one of the objectives of these programs is to have a cost-ameliorating impact in the long run. The trouble is that the tax cap will begin in the front run. It will have a time-certain beginning, and prevention programs do not have an immediate impact on the care delivery system or on the price of insurance. They do over time.

Employers and employees are going to be hard pressed to negotiate significant changes in the hospital-surgical medical side of the benefit as the first thing to be reduced.

If the tax cap is all encompassing, then the things that will certainly be reduced early are those that are not generic to the basic plan. Then management and labor will wait and see how much is left. Then they may begin to cut again.

We feel, if you are going to go ahead with the tax cap, that you ought to do that in concert with furthering the commitment of this Nation to the right balance of health and medical care. It's a balance we never have had, and we might as well seize the opportunity to get it.

The CHAIRMAN. Well, you might be able to design it in some way to encourage the latter.

Mr. GOLDBECK. You absolutely could.

The CHAIRMAN. Yes.

Mr. GOLDBECK. Conversely, I will be very strong in saying that if you had the cap, and you did not have the prevention programs under the cap, you would see an explosion of preventive health programs in the United States at the work setting, and that would be one favorable outcome, if you've got to go ahead with it at all.

The CHAIRMAN. Well, a lot of things could be done. It all depends on where the votes are—as we learn from time to time.

I may have other questions, but I know we have another 10 witnesses we are to complete by noon, which we will not do, then about 20 this afternoon.

So I think what I may do, if it is satisfactory, is to submit the questions in writing to Mr. Bromberg and other professional folks on the panel.

Thank you very much.

Senator PACKWOOD. Could I ask Mr. Epstein just one last question, and he can submit the answer in writing for me?

The CHAIRMAN. Oh, sure.

Senator PACKWOOD. Three months ago my mother-in-law died. She had a pain in her heart at 5 in the afternoon, went to the hospital, went into intensive care, and died on the operating table about 10 that night. And the cost for the 5 hours, counting the doctors' fees, was $10,000.

I am curious if we pass this if it would have any effect on that kind of cost. At another time I may quiz somebody as to why the cost is that amount for 5 hours; but I would like to know if this bill would have an effect on those costs.

Mr. Bromberg has his hand up.

Mr. BROMBERG. If I might try—I am one of those who hopes that this bill one day generates no revenues. Even though it is a wonderful issue to talk about, the $30 billion you could use for good things.

What I hope this bill does is the other thing—health care reform. And let me give you just one example, and in fact you have a colleague in the House from your State who is promoting something called preferred provider organizations—but an example is that this bill, if passed, would at least give business and labor and hospitals and doctors and others an incentive to think about negotiating fixed prices, to think about innovative delivery systems, to have an employer in Oregon and a union say,

> We can save a lot of money if our people go to this list of doctors who have agreed to do things at this price, and this list of hospitals that has good utilization review and doesn't keep people too long and doesn't have a history of bad utilization review, instead of letting them go anywhere they want, when most of them seem to be going to this small group where the utilization records are very high.

Right now there is no such incentive.

If one out of a hundred businesses take that incentive and do something with it, then at least there will be one out of a hundred cases where prices are negotiated, where utilization comes down, and where bills like that maybe won't be submitted.

And maybe if it doesn't happen 99 out of 100 times, just that one time will be enough to do something about health costs.

So that's what the bill is intended to do. Those of us who see this as a health reform bill are very pleased that it is also a revenue-raiser; but our real reason is that kind of reform, which will bring down costs by bringing down utilization, the number of tests. It will say to somebody, "Don't admit Friday for Monday morning surgery."

Senator **Packwood**. Then what you are saying, Mike, is that without the Federal Government's whip hand on limiting the tax-free benefits, the providers and the physicians and the insurance companies and the employers cannot get together themselves.

Mr. **Bromberg**. No, because it's happening already. I am not saying that at all.

I think Bill Goldbeck said it very well, except all I am saying is that the Federal Government could help accelerate it and move it along by removing this one obstacle which is, How do you get to the collective bargaining table and other places the notion that you have got to do something about this when someone there can say it's free?

I think this bill helps accelerate what has already started. And maybe without Federal legislation it will happen anyway, and maybe Federal legislation will just mess it up, and that's the best argument against it. But I think it will accelerate it.

Senator **Long**. Could I ask Dr. Felts' reaction to that question?

Dr. **Felts**. To Senator Packwood's question?

Senator **Long**. Yes, sir.

Dr. **Felts**. Well, it would be a rather complex answer, and without seeing an itemization of the bill it would be a little difficult to respond; but I think that it is probably indicative of the great expansion in technology we have experienced in the United States with the ability to do things for individuals who experience abrupt illness of this particular nature.

Within the past one to two decades we have advanced beyond the point of being able to simply put an individual to bed and monitor blood pressures, and administer intravenous feedings and fluids to try to keep blood pressure stable, to the point where we can now study arteries, can study the site of injury, the individuals are monitored on expensive computer systems to allow quick responses to perceived inadequacies in their metabolism. And these technologies are terribly expensive.

The capability to do this on a moment's notice within hospitals requires the presence of teams that are expensive to maintain.

Senator **Long**. Doctor, if I might just react to that, it makes me think of a story a lawyer friend used to tell about himself in the establishment of lawyers of that community where I graduated from law school.

He said that he did some law work for one of his clients, and after he had concluded that work the man came to see him. The man said, "Now, how much is the fee?" This gentleman told him what the fee was, and the man just sat there. He didn't move one way or the other, he just sat silently for a moment. Then the fellow said, "I'm glad you said that." The lawyer said, "Why?" He answered, "My doctor has been telling me I have a weak heart, and now I know it's not true." [Laughter]

Dr. FELTS. I might conclude, Senator, on that, that fortunately in many of these instances lives are saved and quality of life preserved for a substantial period of time. And while it is not uniformly successful, certainly we are doing better with it than we were doing one and two decades ago.

The CHAIRMAN. Well, thank you very much, and I assume we can feel free to submit additional questions in writing. And if in fact we come back to this that you will be willing to help us in the future.

Thank you very much.

Next is Raymond Scheppach, executive director, National Governors' Association.

I might say that we are not going to be able to finish all of the witnesses we had scheduled for this morning. I think Senator Durenberger has agreed to come back at 1:30 rather than 2 to complete the morning panel. So from 1:30 until 2 that will be done, then we hope to be back on schedule at 2.

We will try to go until about 12:30.

Mr. Scheppach, I am hopeful that you can summarize your statement for the Governors and indicate whether they are for or against what we are doing. That would be helpful.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, D.C.

Mr. SCHEPPACH. Thank you, Mr. Chairman.

The National Governors' Association appreciates the opportunity to present our views regarding Federal tax policies and health benefits.

The NGA supports a limit on the open-ended tax subsidy for employment-based health plans. The Nation's Governors believe that such a limit would constitute good health policy, good tax policy, and good budget policy.

The Governors believe that Federal policy should encourage a restructuring of third-party financing mechanisms and reimbursement policies that contribute to health care cost escalation. Current financing structures lack sufficient incentives for efficiency and obscure the responsibility for health care costs. The Governors are very concerned over these costs because of their effects on State budgets and on economic access for those in need of medical care.

The State share of medicaid costs constitutes the largest and most rapidly rising single component of most State budgets. The Governors are aggressively pursuing medicaid cost containment initiatives that have dramatically lowered the rate of expenditure increases. However, these Medicaid-only strategies are inherently limited because this constitutes under 10 percent of medical care expenditures.

Because Medicaid is too small to alter the overall structure of the medical care financing and delivery system, the cost of that system inevitably influences Medicaid outlays. Further, efforts to constrain Medicaid reimbursement levels alone can exacerbate cost increases to other payers within the State, which are also of concern to Governors.

Under the existing third-party medical care financing system, those who make resource consumption and allocation decisions are often not accountable for the costs of those decisions. The Governors believe that we need to restructure medical care financing mechanisms so that providers, third-party payers, employers, and consumers will make cost-conscious decisions regarding medical care.

Toward this end, the Congress should act to close the open-ended tax subsidies of expensive employment-based health insurance programs.

The tax exclusion of employer contributions to health insurance plans provides a substantial incentive for choice of more costly health benefits plans over more income, which is taxed. We believe a cap on these exemptions would improve incentives to seek cost-effective health care plans because the additional expense associated with the choice of more costly health care would be taxed on the same basis as additional income. The relatively small costs of such a tax change would fall largely on middle and upper income households.

With respect to budget and tax policies, the Governors are also gravely concerned about the magnitude of current and projected Federal deficits. Unless these deficits are reduced, high interest rates will make it extraordinarily difficult to achieve sustained economic recovery. This in turn would cause further deterioration of State fiscal conditions and the ability of States to provide essential services.

State finances are very sensitive to economic conditions, and many States are continuing to experience very serious unanticipated revenue declines.

The revenues that would be generated by the proposed limitation on tax exemption would of course help this.

This proposal would reduce the estimated $30 billion tax subsidy to relatively wealthy individuals which far exceeds the $21 billion projected 1984 Federal Medicaid expenditures for medical care for the poor. It constitutes good economic and tax policy because it broadens the tax base by reducing significant tax expenditures. This would allow Congress to increase revenues without increasing marginal tax rates. Because the marginal tax rate is not increased, incentives to work and invest capital are not reduced.

In conclusion, Mr. Chairman, the Governors strongly believe that we must reduce both health care cost escalation and the federal budget deficit. Unfortunately, effective resolutions to either problem will be painful for many who are benefited by current policies. A limitation on the tax exemption for employer-paid health benefits is not an exception to this unfortunate reality.

In our view, however, this policy would simultaneously improve the accountability of health care costs and reduce the deficit through reduced tax expenditures on those who are relatively well-off. We therefore support this proposal.

The CHAIRMAN. Thank you very much.

[The prepared statement of Raymond Scheppach follows:]

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION

Mr. Chairman, the National Governors' Association appreciates the opportunity to present our views regarding federal tax policies and health benefits. The NGA supports a limit on the open-ended tax subsidy for employment-based health plans. We believe such a limit would constitute good health policy, good tax policy and good budget policy. Current tax policy encourages, without limit, the choice of more expensive health plans over increased income by exempting from taxation employer contributions for health plans. A limitation on this tax exemption would help to reduce medical cost increases by improving incentives for consumers to make cost-conscious decisions in their choice of health care plans.

It would also reduce the deficit by reducing federal tax expenditures for health benefits provided to those with relatively high incomes. Federal deficit reductions are essential to achieving sustained economic recovery. This particular proposal would achieve revenue increases through broadening the tax base rather than increasing marginal tax rates, so incentives to work would not be diminished.

HEALTH POLICY

I will now turn to a fuller discussion of our views regarding a limitation on the tax exemption for employer contributions to employee health plans. The NGA believes that federal policies should encourage a restructuring of third-party financing mechanisms and reimbursement policies that contribute to health care cost escalation. Current financing structures lack sufficient incentives for efficiency and obscure the responsibility for health care costs. the Governors are very concerned over these costs because of their effect on state budgets and on economic access for those in need of medical care.

The state share of Medicaid costs constitutes the largest and most rapidly rising single component of most state budgets. The Governors are aggressively pursuing Medicaid cost containment initiatives that have dramatically lowered the rate of expenditure increases. However, these Medicaid-only strategies are inherently limited because this program constitutes under 10 percent of medical care expenditures. Because Medicaid is too small to alter the overall structure of the medical care financing and delivery system, the cost of that system inevitably influences Medicaid outlays. Further, efforts to constrain Medicaid reimbursement levels alone can exacerbate cost increases to other payers within the state, which are also of concern to the Governors.

State employee health benefit costs are a significant state budget problem, and private industry is increasingly impatient with the health care cost increases in many states. Scarce resources that could be invested to improve economic productivity are being diverted to expenditures on medical care.

Under the existing third-party medical care financing system, those who make resource consumption and allocation decisions are often not accountable for the costs of those decisions. The Governors believe that we need to restructure medical care financing mechanisms so that providers, third-party payers, employers and consumers will make cost-conscious decisions regarding medical care. Toward this end, the Congress should act to close the open-ended tax subsidies of expensive, employment-based health insurance policies.

The tax exclusion of employer contributions to health insurance plans provides substantial incentives for the choice of more costly health benefit plans over more income, which is taxed. We believe a "cap" on these tax exemptions would improve incentives to seek cost-effective health care plans because the additional expense associated with the choice of a more costly health care plan would be taxed on the same basis as additional income. The relatively small costs of such a tax change would fall largely on middle and upper-income households who enjoy a substantial tax subsidy under current law. In 1984, the annual average cost of a $2,100/year limitation for those with adjusted gross incomes of under $10,000 would be only $7, while for those with adjusted gross income of between $50,000 and $100,000, the average cost would be $96. If all the population with incomes of under $10,000 were exempted from any new tax, the projected federal revenue-increase would be reduced by only 7.8 percent. Even though the impact of this change would be modest for most individuals, the NGA would suggest a phase-in of such costs by exempting current employer contributions until the limits have increased to that level.

BUDGET AND TAX POLICY

The Governors are also gravely concerned about the magnitude of current and projected federal budget deficits. Unless these deficits are reduced, high interest rates will make it extraordinarily difficult to achieve sustained economic recovery. This would, in turn, cause even further deterioration in state fiscal conditions and the ability of states to provide essential services. State revenue structures are very sensitive to economic conditions, and many states are continuing to experience very serious, unanticipated revenue declines. The revenues that would be generated by the proposed limitation on tax exemption would, of course, help to close the huge gap between federal outlays and revenues. It would achieve this largely through revenues from individuals with very substantial incomes who have benefited most from current open-ended tax exemption. Only 8 percent of those with adjusted gross incomes of under $10,000 would be affected by the $2,100 limit, while 28 percent of those with adjusted gross incomes of $50,000 and $100,000 would be affected. This proposal would reduce the estimated $30.1 billion fiscal year 1984 tax subsidy of relatively wealthy individuals, which far exceeds the $21.3 billion projected fiscal year 1984 federal Medicaid expenditure for medical care for the poor. It constitutes good economic and tax policy because it broadens the tax base by reducing a significant tax expenditure. This allows the Congress to increase revenues without increasing marginal tax rates. Because the marginal tax rate is not increased, incentives to work and invest capital are not reduced.

In conclusion, the Governors strongly believe that we must reduce both health care cost escalation and the federal budget deficit. Unfortunately, effective resolutions to either problem will be painful for many who are benefited by current policies. A limitation on the tax exemption for employer-paid health benefits is not an exception to this unfortunate reality. In our view, however, this policy would simultaneously improve the accountability for health care costs and reduce the deficit through reduced tax expenditures on those who are relatively well-off. We therefore support this proposal.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. No questions.

The CHAIRMAN. Senator Long.

Senator LONG. No questions.

The CHAIRMAN. Thank you very much, and your full statement will be made a part of the record.

Mr. SCHEPPACH. Thank you, I appreciate it.

The CHAIRMAN. And I am going to ask that my statement be made a part of the record at the outset of the hearing.

STATEMENT OF SENATOR DOLE ON MEDICAL CAP AND FRINGE BENEFITS

I am pleased that we have been able to hold this hearing on S. 640, the administration's proposal to cap the income tax exclusion for employer-provided medical care, and the public policy and tax compliance implications of the tax treatment of statutory and nonstatutory fringe benefits.

CAP ON THE EXCLUSION FOR EMPLOYER-PROVIDED MEDICAL CARE

Currently, all employee contributions to health insurance plans for employees are excluded from the employee's income and wages for purposes of income tax, social secutity tax and unemployment tax. This tax treatment generally applies to all insurance coverage, regardless of cost, and to all medical benefits, no matter how extensive. The same generally applies to amounts paid by an employer to or on behalf of an employee under a self-insured medical plan.

Under S. 640, Employer contributions to accident or health plans for an employee would be included in the employee's income to the extent they exceed (1) $175 per month ($2,100 per year) if the plan covers the employee and his family, or (2) $70 per month ($840 per year) if the plan covers only the employee.

The total exclusion from an employee's income for employer paid medical coverage is the second largest statutory fringe benefit after qualified pension and similar plans. The revenue loss from the exclusion for employer-provided medical care is estimated to be $18.6 billion in fiscal year 1983 and $21.3 billion in fiscal year 1984. Many experts believe our present tax treatment of employer-provided health benefits has been a contributing factor in the trend toward excessive coverage and escalating medical costs. In addition, it has created inequity between the tax treatment of individuals covered by employee health plans and those who are not covered by employer-provided plan. Some also believe that the preferential tax treatment of employee paid health benefits encourage employees to receive an inordinately large amount of their compensation in the form of health benefits.

As we review S. 640, there are still a number of unanswered questions. For instance, should there be a national cap on one which varies in different areas of the country recognizing the different costs of medical care; the impact of the cap on various segments of our society; will the healthy choose low option and the sick high option insurance resulting in unfair tax consequences to our sick and elderly? In addition, we must examine how to deal with self-insured plans which are increasing in number.

STATUTORY FRINGE BENEFITS

The hearing will also focus on the current provisions of the income law that allow employers to deduct the cost of providing employee benefits, but excludes the amounts paid, in whole or in part, from the employee's gross income. Congress has a responsibiltiy to the public to review periodically the income tax provisions to determine if they are achieving their intended objectives and to determine if tax policy and social policies necessitate continuing the preferential tax treatment is justified. The purpose of this hearing is not to determine whcih of these tax preferences should be deleted in order to raise revenue, but to review these provisions generally in light of their stated objectives and the continually evolving social policies.

NONSTATUTORY FRINGE BENEFITS

Finally, the hearing will focus on the public policies and tax compliance implications of the nonstatutory fringe benefits and the effect of the moratorium on fringe benefit regulations which is scheduled to expire on Decempber 31, 1983. The current moratorium is an extension of a moratorium that was first imposed on October 1978.

Undoubtedly, there is substantial sentiment that certain benefits are so small and difficult to value that they should not be taxed as a matter of administrative convenience. But it is very hard to draw the line. Attempts by the Treasury Department to draft guidelines in 1977 and 1981 were met with opposition, disagreement, debate and a moratorium. But the absence of guidelines on the proper taxation of noncash compensation has left employees, employers and IRS agents confused and uncertain.

The uncertainty as to the taxation of certain fringe benefits has also affected our voluntary compliance system. Many taxpayers have sought noncash compensation in the hope or belief that they would avoid taxation in this unsettled and confused area. In addition, public confidence in the fairness of our tax system and the unequal tax treatment of equal economic incomes of cash and noncash compensation has eroded public confidence in the fairness of our tax system.

As we review the medical cap proposal and the tax treatment of statutory and nonstatutory fringe benefits, we must keep in mind that, as our tax base becomes smaller and smaller and as our tax compliance problem grows, more and more pressure will be exerted to increase the tax rates on cash wages.

I look forward to hearing the views of the administration and the public witnesses on all these important tax issues.

Now, Bert, you are next.

STATEMENT OF BERT SEIDMAN, DIVISION OF SOCIAL SECURITY, AFL-CIO, WASHINGTON, D.C.

Mr. SEIDMAN. Thank you, Mr. Chairman.

I am Bert Seidman. I am director of the Department of Social Security of the AFL-CIO.

To my right is Lawrence Smedley, who is an associate director of the department, and to my left, Karen Ignagni, an assistant director.

We are here today to present the views of the AFL-CIO on the taxing of fringe benefits and the specific proposal to place a limit on tax-exempt contributions to employee health insurance—changes we hope you will decide are unfair, ill-advised, and should not be enacted.

The AFL-CIO strongly opposes the administration's attempt to impose a ceiling on tax-exempt employer contributions to employee health insurance plans.

This plan, if enacted, would represent unprecedented Government intrusion into the collective bargaining process. Further, there is no guarantee that it will lower health-care costs or increase Federal revenues. It would provide a strong incentive for unions to seek to have employer contributions which exceed the Federal cap switched to other fringe benefits.

Individuals with higher incomes will probably purchase supplemental health insurance policies so that their present coverage will not be interrupted. Those who will be penalized and who will not be able to maintain their benefits are middle-income and lower aged workers, and I might add to that older and handicapped workers.

Contrary to the commonly held belief that only members of the autoworkers and steelworkers would be affected by the administration's proposal, we have looked into it in not a very systematic way and find that a large number of other union members would suffer, including those in various unions which I have set forth in my testimony. All of them have plans which exceed the proposed limit of $175 per family per month.

Other employees are covered by plans that may not be highly comprehensive but nevertheless exceed the proposed limit. Their high premium rates reflect high health-care costs in their areas, over which they have no control, or the age and health status of their group, or both.

Mr. Chairman, the AFL-CIO has seven basic problems with the administration's proposal:

One, worker benefits negotiated through collective bargaining should not be subject to the vagaries of the Tax Code.

Two, workers in high-cost areas will be severely penalized.

Three, employees with chronic conditions and older workers will be forced to purchase expensive supplemental insurance.

Four, the proposal would discourage hiring of older and handicapped workers as well as those with higher health-care costs for any other reason.

Five, it would reduce coverage for preventive care, outpatient diagnostic services, dental, eyeglasses, and other benefits which save money. It would leave intact coverage for hospital and surgical benefits which are the most inflationary sector of the health-care economy.

Six, it discriminates against workers in unhealthy industries with high health-care costs.

Seven, the plan would be almost impossible to administer for the self-insured.

And, finally, it would require opening up large numbers of existing labor contracts.

Proponents of taxing workers' health insurance believe that since workers are not taxed directly for health-care benefits, they become overinsured, and that this has altered the traditional pattern of consumption as determined by price, supply, and demand.

Workers know that health care is not free to them—far from it. Workers make tough economic decisions and pass up other benefits, including wages at the bargaining table, to preserve the health-care coverage they do have.

A major flaw in the argument that insurance protection insulates consumers from the high cost of medical care and encourages them to utilize services is that consumers do not directly purchase health care. Physicians and other providers act as the purchasing agents of the consumer. And therefore it is unfair to penalize employees for situations over which they have no little or no control.

Real cost containment will not be possible until providers and suppliers of services have strong financial incentives to change their behavior and help bring inflation under control, and that's why we urge Congress to enact comprehensive across-the-board health-care cost-containment legislation.

With regard to taxation of other benefits, current legislation preventing the issuance of new regulations relating to the income tax treatment of fringe benefits will expire on December 31, 1983, unless the moratorium now in effect is extended. Given the controversial and complex nature of the subject, the history of past efforts, and the pending congressional workload, we doubt that the Congress can satisfactorily legislate on this issue prior to the end of this year. For that reason, the AFL–CIO supports extension of the moratorium so that this issue can be reviewed extensively and exclusively on its merits and not in the context of budget resolutions and revenue needs.

Mr. Chairman, I request that my full statement be included in the record of the hearing.

The CHAIRMAN. It will be made a part of the record.

[The prepared statement of Bert Seidman follows:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL–CIO commends you, Mr. Chairman, for conducting hearings on the proposals submitted to Congress by the Administration in its proposed budget for fiscal year 1984. When these hearings are concluded, we hope the Committee will decide most of these proposals are unfair, ill-advised and should not be enacted.

Organized labor is heretoday to present it views on the taxing of fringe benefits and the specific proposal to place a limit on tax-free contributions to employee health insurance.

The AFL–CIO—a federation of 98 unions representing 13.7 million working men and women—strongly opposes the Administration's attempt to impose a ceiling on tax-free employer contributions to employee health insurance plans. This plan, if enacted, would represent unprecedented government intrusion into the collective bargaining process. Further, there is no guarantee that it will lower health care costs or increase federal revenues.

In 1949 the Supreme Court in its decision on Inland Steel vs the NLRB affirmed the right of employees to negotiate with employers about fringe benefits. The negotiating process has always been carried out without government interference. Placing a limit on tax-free employer contributions to health insurance, and making anything over that amount taxable as income to employees, would provide a strong incentive for unions to seek to have employer contributions which exceed the federal cap switched to other fringe benefits.

Individuals with higher incomes will probably purchase supplemental health insurance policies so that their present coverage is not interrupted. Those who will be penalized, and will not be able to maintain their benefits, are middle income and lower wage workers.

Contrary to the commonly held belief that only members of the United Auto Workers and the Steelworkers would be affected by the Administration's proposal, a large number of other union members would suffer, including those in the Machinists, the Letter Carriers, Operating Engineers and the American Federation of State, County and Municipal Employees. Members in some of these unions have comprehensive health insurance plans, other have less comprehensive coverage. However, all of these plans provide coverage to workers and their families at a cost that exceeds the proposed limit of $175 per family per month.

For those employees who do not have policies which could be considered as highly comprehensive, but which nevertheless exceed the proposed limit, their high premium rates reflect high health care costs in their areas over which they have no control, or the age and health status of their group, or both. For example, health benefit contributions for employees of the International Union of Electrical Workers ranged from 80 cents per hour in Oklahoma and Texas to $1.16 per hour in California and $1.41 in New Jersey.

Mr. Chairman, the AFL-CIO has seven basic problems with the Administration's proposal to limit tax exempt contributions to health insurance. They are:

1. Worker benefits negotiated through collective bargaining should not be subject to the vagaries of the tax code, which force distortion in coverage and encourage circumvention of the process.
2. Workers in high cost areas will be severely penalized by a national cap.
3. Employees with chronic conditions and older workers will be forced to purchase expensive supplemental insurance.
4. The proposal will discourage hiring of older workers and those with higher health care costs.
5. It would reduce coverage for preventive care, out-patient diagnostic services, dental, eyelgasses and other benefits which save money. It would leave intact coverage for hospital and surgical benefits, which have been the source of our health inflation problems and over which patients have little control.
6. It discriminates against workers in unhealthy industries, such as coal and steel, where health care costs are higher.
7. The plan would be almost impossible to administer for the self-insured. Since they do not pay premiums, it would be difficult for tax purposes to determine monthly employer contributions.
8. It would require opening up large numbers of existing labor contracts, while the issue of whether the proposal will reduce overall health costs is, at best, open to question.

Proponents of taxing workers' health insurance believe that since workers are not taxed directly for health care benefits, they have become overinsured, and that this has altered the traditional pattern of consumption, as determined by price, supply and demand. The so-called "market solution" is to provide an incentive through the tax system to reduce health insurance protection and increase employee cost sharing, which will in turn reduce the demand for services and lower the price of treatment. Other supporters of tax caps have suggested that tax subsidies for employee health insurance amount to a welfare program for the middle class.

As the representatives of organized labor, we would like to make it clear that health care is not free to workers. Far from it. Workers make tough economic decisions and pass up other benefits, including wages, at the bargaining table to preserve the health care coverage they do have. Recently auto workers at Chrysler were willing to accept wage concessions just to preserve their health care coverage, which has become increasingly difficult because of the rapid rise in health insurance premiums.

In many ways the so-called "tax cap" is a strawman for those who have a fundamental aversion to the idea of the federal government regulating what are now staggering rates of increase in hospital costs and physician services. However, these same individuals are not unwilling to impose a limit on employer funded health insurance benefits because they believe that shomehow taxation of health care benefits would dampen health care inflation.

A major flaw in the arugment that insurance protection insulates consumers from the high cost of medical care and encourages them to overutilize services is that consumers have never directly purchased health care. Physicians act as their purchasing agents and make such decisions as whether a person should be hospitalized, what tests should be performed and when they should be discharged. It is unfair, therefore, to penalize employees for situations over which they have little or no control.

Several months ago in our testimony on the Administration's proposal to begin reimbursing hospitals which participate in Medicare on the basis of diagnostic related groupings (DRGs), the AFL-CIO stated its position that real cost containment is not possible until the providers and suppliers of services have strong financial incentives to change their behavior and help bring inflation under control. Mr. Chairman, we would like to submit that statement for the record as part of our testimony on taxing fringe benefits and again strongly urge that Congress enact comprehensive across-the-board cost containment legislation.

The Administration's proposal to put a ceiling on tax-free employer health care contributions would turn back the clock on decades of progress workers have made. It would increase taxes for a single group—workers with high health care costs.

Last February William M. Mercer, Inc., polled 78 employee benefit executives. Sixty-five percent said they oppose placing a limit on tax-free contributions by employers to health insurance plans for their employees, and that it will not reduce health care costs.

This Committee must ask itself whether health care is the right place to look for ways to reduce deficits. It must not confuse cost containment with revenue raising.

TAXATION OF OTHER BENEFITS

In 1976, the Internal Revenue Service proposed regulations that would have reversed long-standing positions and practices in order to broaden the taxation of fringe benefits. These proposals would have increased taxes on some of the nation's lowest paid workers.

Congress correctly took the position that fringe benefit policy should not be determined by unilateral agency action but by the Congress and, therefore, enacted legislation preventing the issuance of new regulations relating to the income tax treatment of fringe benefits until July 1, 1978. Congress has periodically extended the moratorium. Unless extended again, this moratorium will expire on December 31, 1983.

Given the controversial and complex nature of the subject, the history of past efforts and the pending Congressional workload, we doubt that the Congress can satisfactorily legislate on this issue prior to the end of the year. The AFL-CIO supports extension of the moratorium so that this issue can be reviewed intensively and exclusively on its merits—not in the context of budget resolutions and revenue needs.

In reviewing the tax treatment of fringe benefits, the Congress and the Committee should endeavor to provide workers and empolyers with a greater degree of certainty. Administrative action should not be the basis for the taxation of fringe benefits which traditionally have not been taxed. The best approach would be for Congress to develop a set of principles or standards. In the development of guidelines the following principles should be included:

1. Sensible "de minimis" rules so that employers and employees need not take into account small benefit values which would cause unreasonable record keeping and administrative burdens.
2. Benefits that facilitate the employee's work performance, are provided for the convenience of the employer, or other support services, such as the furnishing of uniforms should not be taxed.
3. Limited benefits historically and broadly available such as discounts for employees of retail stores should be exempt from taxation.
4. Provisions of present law which under specified conditions expressly grant tax exemptions for fringe benefits including, among others, qualified pension plans, group life insurance, health benefits, and group legal services should be continued.

In addition, the development of measures to change current practice relating to the taxation of fringe benefits must be considered in the context of other measures to require the wealthy and the corporations to pay their fair share of the tax burden. They must not add to the unfair tax burden borne by workers, and particularly should not be targeted as a source of revenue to make up for the huge and inequitable tax cuts of 1981.

The CHAIRMAN. Does the AFL-CIO support the budget resolution that has been agreed to in conference—$73 billion in additional revenue?

Mr. SEIDMAN. I don't know. I wish one of our representatives from our legislative department was here. Bob McLawton was here earlier and had to leave. It is my understanding that we haven't reached a policy decision on that question yet, but I frankly can't give you a definitive answer.

The CHAIRMAN. Do you support the O'Neill-Byrd tax cap?

Mr. SEIDMAN. Yes, we do.

The CHAIRMAN. For what reason?

Mr. SEIDMAN. We support it because we think that the wealthy and the large corporations have derived a tremendous benefit from the tax reductions in the legislation of 1981, and we think that this would help in some small measure to rectify that.

The CHAIRMAN. Well, now, if we could devise a cap, sort of a health care cap like the tip cap so we wouldn't be helping any wealthy people—I don't know what wealthy is, but apparently you are now supporting the wealthy in your testimony today, but you want to take away their tax cuts.

Mr. SEIDMAN. We think this has many other implications, however, that are not involved in the single question of the cap on the tax reduction that is involved in what the House has voted for.

We tried to indicate in our statement and in previous statements we have gone into this in much greater detail—we think it has an impact on collective bargaining, we think it has an adverse effect on health care costs rather than reducing health care costs, we think that it places an unfair tax on workers, we think that it involves increased administrative costs, it involves the various kinds of discrimination which you have heard about during the course of the hearing this morning, and, therefore, we are strongly opposing this proposal.

The CHAIRMAN. No, I know of the opposition. I don't quarrel with it, but it seems to me it is not consistent to say, on the one hand, you can't have a tax cut if you make over $30,000 or even less if both husband and wife are working, but you can have unlimited benefits that are not income to the employee. It would just seem to me if we are going to go after the rich, whoever they are, then we ought to do it on a consistent basis. And I would hope that you would work with us as we try to design a cap that you might be able to support.

Mr. SEIDMAN. I think it would be very difficult for us to find any kind of a viable proposal which would deal with all of the problems that are raised by the tax cap. I think the situation is entirely different from a tax on income, per se.

What we are talking about here is people getting, under employer-financed plans, decent health care that they need. We think that the emphasis should be on controlling health care costs through all-payer systems such as we have now in a number of States, through systems which cover all aspects of health care costs and not just medicare and medicaid. We think those are the ways of dealing with the problem.

As far as unions are concerned, we are very, very sensitive to health care costs—we have to be. Very few workers have anything like first-dollar coverage. The only workers who have first-dollar coverage, even if they have it, is in HMO's which provide comprehensive cost-effective care.

Under other programs we don't have first-dollar coverage, and that, as far as we are concerned, is a kind of a red herring.

The CHAIRMAN. Well, we don't know precisely what we will do, if anything, but it seems to me we've got to get some handle on health care costs.

Mr. SEIDMAN. We agree with you on that.

The CHAIRMAN. Would costsharing be a better area to explore?

Mr. SEIDMAN. We already have costsharing.

The CHAIRMAN. Very little in many areas.

Mr. SEIDMAN. No; we have a great deal of cost-sharing. Even under the best collective-bargaining contracts workers generally pay out-of-pocket about 50 percent of their health care costs. So we have a great deal of health care cost-sharing already.

We think that cost-sharing provides unnecessary financial barriers to cost-effective care.

The CHAIRMAN. So I guess you propose then to go back to mandatory cost-containment as the way to deal with this.

Mr. SEIDMAN. We do. You have already done this to some extent in the legislation which you have just enacted, but we think it ought to be much more comprehensive in its approach.

The CHAIRMAN. Thank you.

Senator Durenberger.

Senator DURENBERGER. No questions.

The CHAIRMAN. Senator Long.

Senator LONG. I could tell by your reaction when Mr. Bromberg was speaking of negotiating with doctors, that you didn't think that would work. I would like to know why you don't think that might be an area to be explored—to negotiate on behalf of your people with doctors to get a better deal on treatments and things that would keep him busy doing whatever his line of endeavor might be, provided that he would give them a good rate.

Mr. SEIDMAN. Some health and welfare plans of course have done that. We are not opposed under collectively bargained contracts to developing contracts with physicians or with other providers. HMO's have done that, and many unions are supporting HMO's which are doing it, and we see nothing wrong with that. We would like to see it extended. We would like to see this in legislation so that the negotiation would take place not just for particular groups of workers but for the health care economy as a whole.

Many countries have done this successfully, and we would like to see something like that in the United States; but until we do have such legislation, I'm sure that increasingly people will be turning to that as one way of dealing with health care cost problems.

I would like to emphasize that the argument that is being made that unions and employers are completely insensitive to these escalating health care costs—I don't know if that was ever true, but we certainly don't see any evidence of it today. To the contrary, both labor and management are extremely sensitive to health care costs; that is one of the reasons why we have joined with our unlikely partners who have been at this table before us in coalitions, to try to deal with the health care cost problem. We are sensitive to these problems, and we want to do what we think can be done in a fair way and an effective way to deal with them.

Senator LONG. Well, we have difficulty getting enough doctors to take care of the elderly people in nursing homes. Doctors don't particularly like to do that kind of work. I guess it's kind of depressing. Everybody has to die someday, and most of those dear old souls who leave those nursing homes are going to go out of there in a hearse, in fact that's how practically all of them leave there. And it's depressing, so I guess doctors don't particularly like to do it.

We ought to train enough doctors in this country so that there are doctors available to do all the things we want done. They make good pay. It's a good job—in terms of pay and fringe benefits. It certainly is.

It seems to me that somebody, and I don't know who better than organized labor, ought to think in terms of increasing the supply of trained people until some of this work that doctors need not do can be done by corpsmen. For example, a corpsman can certainly give anybody a shot that he needs. Everything does not have to be done by the doctors; some of the work could be done by registered nurses and corpsmen instead of being done by the doctors.

When I was a young lawyer I would have been delighted to negotiate with anybody I could find to represent some of your people with workmen's compensation work and with anything else you might have had to do, because I didn't have much law practice when I started out, just like most young lawyers when they start out on their own. I would think you could get yourselves some pretty good deals if you would negotiate for it.

In that case you would be doing the hiring, but I see nothing wrong with that. You know, I'm very much of an employee-ownership type guy. I kind of look forward to the day when in more and more companies labor will hire management rather than management hiring labor.

Mr. **Seidman**. Well, increasingly I think that unions are doing exactly what you are saying. The autoworkers have done that with certain types of providers, the steelworkers have been trying to get management interested in doing that in that industry, and many health and welfare plans have been doing it.

May I also just say that we thoroughly support the beginning movement toward development of schools of gerontology so that there will be people to take care of the people in nursing homes. And we certainly agree with you that there should be much more use and effective use made of paraprofessionals and others in the health care industry. And some of our unions in hospitals and other types of health care institutions have negotiated so that there are what are called "ladders of opportunity" for workers at lower levels to become trained to be able to provide the higher levels of care and thus relieve the doctors and the nurses of doing work that others would be able to do.

Senator **Long**. Thank you, Mr. Seidman. It is always good to have you before the committee.

The **Chairman**. Thank you very much, and we will be keeping in touch.

Mr. **Seidman**. Thank you.

The **Chairman**. I think what we might do is to take Mr. Germanis and Mr. Simon, and then the final panel could come back at 1:30—Mr. Hutchings, Mr. Salisbury, and Mr. Chip. Senator Durenberger will be here at 1:30. Some are just here every day, anyway. [Laughter.]

We are told we are about to have some votes.

Let's see—it's Karla Simon? No? Well, that's a bonus. [Laughter.]

Peter, do you want to speed it up here? We will ask that you put your statement in the record and summarize if you can.

Mr. GERMANIS. OK.

STATEMENT OF PETER G. GERMANIS, ECONOMIST, ON BEHALF OF THE HERITAGE FOUNDATION, WASHINGTON, D.C.

Mr. GERMANIS. In the interest of time, then, I will summarize the summary of my prepared statement.

The current tax treatment of employer-sponsored health insurance has contributed to the third-party payment problem and has been an important factor in discouraging competition in the health care sector. This tax provision distorts the real cost of employer-based health insurance relative to other goods and services in the economy which must be purchased with after-tax dollars. It has led to general overinsurance, frequently covering costs traditionally paid for by employees themselves.

Perhaps the best way to avoid the distortionary effects caused by this exclusion would be to move toward a flat rate tax system with no deductions or exclusions. Health care would then compete fairly with all other goods and services on the open market.

However, if the Nation is not ready to move quickly to a flat rate tax system, other options such as the proposed tax cap should be considered.

I believe that this reform would promote a competitive environment in the health care industry by making both employers and employees more cost-conscious when purchasing health insurance for medical care. Those with insurance premiums above the tax-free limit would have to choose a less costly alternative or pay tax on the amount over the limit. Those choosing the former course might select plans that have greater cost-sharing, or they may choose less expensive alternative delivery systems that provide cost-effective quality care such as HMO's.

Some argue that the tax cap will not have the anticipated effect on tax revenues because employers will merely shift money spent on excess health insurance into other nontaxed fringe benefits. While this may be true to some extent, it ignores the fact that the purpose of the cap is to restrain the growth of health care costs due to inappropriate demand. The aim is not to raise tax revenues.

Others who believe that the tax cap will raise revenues contend that the proposal, just as any other tax increase, will have disincentive effects on the economy. In my opinion, however, continuing the open-ended nature of this tax exclusion will further erode the tax base and contribute to rising marginal tax rates.

We have to remember that whenever we have a tax expenditure, that money is going to come at the expense of Federal revenues, and the people who don't have employer-sponsored health insurance plans are probably the ones who will pay the most, since they will have to pay higher taxes than they otherwise would have if this drain on revenue weren't in effect.

Thank you very much.

The CHAIRMAN. Thank you very much.

[The prepared statement of Peter Germanis follows:]

STATEMENT OF PETER G. GERMANIS, ECONOMIST FOR THE HERITAGE FOUNDATION

My name is Peter Germanis, and I am an economist at the Heritage Foundation. I welcome the opportunity to appear before this Committee to present my views on the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income.

While a number of factors have contributed to the rapid rise in health care costs, perhaps the most important of these is the practice in America of third parties, such as insurance companies and governments, paying most medical expenses. In 1981, for example, third parties paid over 65 percent of medical expenses in general, and nearly 95 percent of the nation's hospital bill.

These third-party payments, frequently provided on a group insurance basis, artificially inflate the demand for health care because of the direct cost of services to covered patients is sharply reduced. This drives up the price of medical care and leads to great inefficiencies by encourgaging people to use health care service options without regard to their comparative cost. Moreover, many of these services are only of marginal benefit to the patient and are undertaken largely because a third party bears the expense. Because of the group nature of most insurance, heavy utilization by an individual does not directly affect his premium—the extra costs are shared by the group.

Similarly, providers of health care enjoy incentives to provide excessive care because they know that their services are nearly cost-free to the patient and will earn them greater revenues. In fact, the practioner is almost duty-bound to prescribe care if it has any positive value, regardless of cost.

The tax treatment of employer sponsored health insurance has been a major factor in discouraging competition in the health care sector. Although the tax code does not subsidize individual medical expenses, except in cases where the costs exceed a threshold based on adjusted gross income, it does subsidize employee health insurance benefits paid on their behalf by their employers. The current law encourages the purchase of excessive health insurance coverage because it allows employers who offer employee health insurance plans to deduct their contributions as business expenses. Employees, meanwhile, receive these benefits tax free.

This tax provision distorts the real cost of employer-based health insurance relative to other goods and services in the economy which must be purchased with after-tax dollars. It has led to general overinsurance and has encouraged first-dollar coverage, frequently covering costs traditionally paid for by employees themselves. Moreover, once insurance becomes completely comprehensive, people lose any incentive they might otherwise have had to seek out the most cost-efficient care. They also have incentives to use any procedure or treatment available since the apparent costs to them become zero.

Thus, the effect of this exclusion has been to further weaken the link between the patient and the cost of tretment. Perhaps the best way to avoid the distortionary effects caused by this provision would be to move toward a flat-rate tax system with no deductions or exclusions. Health care would then compete fairly with all other goods and services on the open market.

However, if the nation is not ready to move quickly to a flat-rate tax system, other options could be considered. The Administration proposes to limit the tax-free treatment of employer health insurance premium contributions to $2,100 annually for family plans and $840 annually for individual plans. Any contribution exceeding this would be treated as taxable income for the employee.

This proposed reform would promote a competitive environment in the health care industry by making both employers and employees more cost conscious when purchasing health insurance and medical care. Under the proposal, those with insurance premiums above the tax-free limit would have to choose a less costly alternative or pay tax on the amount over the limit. Those choosing the former course might select plans that have higher deductibles and copayments, but still provide coverage against large and unexpected medical expenses. The evidence suggests that even modest cost-sharing could dramatically reduce excessive demand for health care services by increasing consumer awareness of costs.

Others may choose less expensive alternative delivery systems, such as Health Maintenance Organizations (HMOs), that provide cost-effective quality care. (HMOs avoid the perverse incentives associated with the fee-for-service and cost based reimbursement mechanisms by operating as prepaid health plans. Because these groups are paid in advance, they have financial incentives to minimize costs by curtailing unnecessary services.

Opponents of the tax cap proposal argue that additional cost-sharing may be difficult for low income families and that they may delay or forget the routine medical services that keep them healthy and out of expensive hospitals. Among the cost-effective services they fear would be dropped are outpatient and preventive care services, early diagnosis and treatment, dental, vision, mental, and home health services.

This argument would have some merit, were the cap set at a very low level. In fact, the Administration's ceiling is high enough to leave unaffected the coverage of most low income employees. According to White House economic adviser Martin Feldstein, less than 5 percent of families with incomes below $15,000 a year would be affected. There is also nothing in the proposal to prevent people from buying supplemental health insurance with their after-tax income if they believe the additional benefits to be worth the cost.

Some critics point out that a tax on health insurance premiums would be difficult and costly to administer. These regulatory burdens, they argue, would be particularly onerous for small businesses, which cannot afford to hire the experts needed to monitor regulatory and tax changes. The Administration estimates that only 18 percent of all workers and 30 percent of those with health insurance will be affected by the cap in 1984; therefore, most businesses will not face an increased administrative burden. David Winston, a consultant to the White House on health issues, also points out that the proposal only sets a limit on the amount of health insurance that is tax deductible and that it should not impose an unreasonable accounting burden.

Others claim that a uniform limit would penalize people living in areas with exceptionally high medical costs. These critics propose that the limit vary by location and actuarial group. But this would complicate administration and establish a precedent for regional variations in the tax code based on differences in the cost of living. If the cap, moreover, introduces the greatest price constraint in high-cost areas, it is precisely there that downward pressure on prices is most needed.

Other critics argue that the tax cap will not have the anticipated effect on tax revenues because employers will merely shift money spent on excess health insurance into other nontaxed fringe benefits. While this may be true to some extent, it ignores the fact that the primary purpose of the cap is to restrain the growth of health care costs due to inappropriate demand. The aim is not to raise tax revenues.

Those who claim that the tax cap will raise revenues contend that the proposal, just as any tax increase, will have disincentive effects on the economy. In my view, however, continuing the open-ended nature of this tax exclusion will further erode the tax base and actually contribute to rising marginal tax rates. Moreover, the proposal will at least have the benefit of restoring market forces to the health care sector.

The CHAIRMAN. Senator Long.

Senator LONG. No questions.

The CHAIRMAN. Your entire statement will be made a part of the record, and we appreciate it.

Mr. GERMANIS. Thank you.

The CHAIRMAN. We will stand in recess until 1:30. At that time we will have a panel of Mr. Hutchings, Mr. Salisbury, and Mr. Chip.

[Whereupon, at 12:30 p.m., the hearing was recessed.]

Senator DURENBERGER. Gentlemen and women, this is our final morning panel: Peter Hutchings, partner, Kwasha Lipton of Fort Lee, N.J., on behalf of the Association of Private Pension and Welfare Plans; Dallas L. Salisbury, executive director, and Dr. Deborah Chollet, Employee Benefit Research Institute; and William W. Chip, an attorney on behalf of the Employers Council on Flexible Compensation.

Thank you all for being here, and we will start with Peter—or, if you have a preference, we will go with Mr. Chip.

Mr. CHIP. Peter has kindly allowed me to speak first.

STATEMENT OF WILLIAM W. CHIP, ATTORNEY, IVINS, PHILLIPS & BARKER, ON BEHALF OF THE EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION, WASHINGTON, D.C.

Mr. CHIP. I would like to use my few minutes to focus on one misimpression that I believe might have been left by Mr. Chapoton when he spoke this morning.

The Treasury has expressed some concern, on what I assume is basically a theoretical basis rather than the basis of any actual statistics, that cafeteria plans, by virtue of allowing employees the option to decide how much of their compensation will be in benefits and how much will be in cash, will lead to more utilization of tax-free benefits than is now the case.

Clearly, if you believe that, and if you believe that the tax subsidy inherent in tax-free benefits is a driving force in their utilization, that would be inconsistent with the purpose of S. 640, which is to control health care costs.

We heard a lot of talk this morning about S. 640 and what it will accomplish, and of course it is all speculation because until it is enacted no one really knows for sure what will happen; but in the case of cafeteria plans, which have been permitted since 1978, we do have experience, and we can see what has actually happened.

American Can Co., which has one of the oldest cafeteria plans in the country, maintains, like most companies with such plans, a cafeteria plan for some of its employees but maintains a more traditional type of plan for the rest of its employees. And their experience has been that when you give employees the option of choosing less expensive medical coverage and receiving a cash rebate or some other benefit instead, then in fact many employees are willing to choose more economical coverage.

As a result, to give you some numbers, in the period 1980 to 1981 the cost of American Can's medical plan for the nonflexible medical plan went up 19 percent. The cost of their flexible medical plan only went up 9 percent.

In 1981 to 1982, the cost of their nonflexible, traditional medical plan went up 30 percent, primarily because of hospitalization costs. The cost of their flexible plan went up only 10 percent.

Pepsico, a company which produces that fine soft drink and other things, has more recently implemented a cafeteria plan which covers 20,000 employees, so it is a very large group and I think is very good statistically as opposed to a small group which might not represent the economy at large. The Pepsico statistics relate to what happened between 1982 and this year. The cost of providing medical benefits for employees covered by the cafeteria plan went up 11 percent. The cost of providing medical benefits to employees who were not covered by the cafeteria plan went up 18 percent. This is an experience which is being recapitulated in company after company as the flexible-compensation concept becomes more popular and more accepted.

Unfortunately, the failure of the Internal Revenue Service to issue any kind of guidance in this area has caused a lot of companies to hold off. And I might add that I believe some of the perceived abuses of these programs that bother the Treasury are equally the result of the failure of the Treasury to give any guidance in this area.

Speaking as an attorney, not representing ECFC, when people come to me and say, "I'd like to do this with my cafeteria plan," and I say, "Well, I'm not sure you are permitted to do that," they say, "Well, prove it." And I say, "Well, there are no regulations that I can cite. I would advise you to go to the Internal Revenue Service and ask them to rule on your plan." But the Service won't rule on their plan. It's sort of a catch-22. They won't rule because they don't have regulations.

But I think most companies believe that after a few years you really can't allow the Treasury to sort of repeal tax legislation by refusing to issue rulings and regulations, and have gone ahead. The results so far I think have been very favorable if you are really interested in keeping down health care costs.

Thank you.

Senator **DURENBERGER**. Thank you.

[The prepared statement of William Chip follows:]

PREPARED STATEMENT OF WILLIAM W. CHIP ON BEHALF OF THE EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION

The Employers Council on Flexible Compensation ("ECFC") is the national spokesman for the growing number of companies in this country that offer programs of flexible compensation to their employees. A list of ECFC's current membership is attached to this statement.

INTRODUCTION

ECFC is aware of this Committee's concern about the increasing cost of certain "fringe benefits" provided by employers to employees. Because some of these benefits are not taxed, their increasing costs cause a drain on tax revenues. A potential response to this problem is to place dollar limits or "caps" on the amount of a particular benefit that may be received free of tax.

ECFC believes it is uniquely qualified to testify on the issue of "capping" tax-free fringe benefits, because flexible compensation can itself be a significant tool for controlling the costs of fringe benefits.

Flexible compensation simply means that employees choose their own benefits from a menu of benefits offered by their employer. Few employers can afford to offer their employees all the taxable and nontaxable fringe benefits that are on the market today. Without flexible compensation, most employers are forced to provide a narrow range of benefits to the entire workforce even though many employees may have a greater need for the benefits that are not provided. A classic example is the working mother who is receiving medical insurance coverage that duplicates the coverage already provided by her husband's employer. Her own employer's contribution for medical coverage represents wasted money that, from her point of view, might have been better spent on adequate day care for her children. In a flexible compensation plan, the working mother might be permitted to give up duplicative medical coverage in exchange for day care or cash. In effect, flexible compensation makes it possible for the employer to offer a broad range of benefits and allow the employee to use the limited pool of benefits dollars to choose the benefits that he or she really needs.

Because flexible compensation permits employees to make decisions about the division of their compensation between taxable and nontaxable benefits, the implementation in a flexible compensation plan may alter the amount of tax that would be paid by the plan participants. To the extent an employee chooses a lower level of tax-free benefits in order to increase his cash compensation, the income tax base is enlarged. To the extent an employee elects more tax-free benefits and less cash compensation, the tax base is diminished. Initial experience with flexible compensation is that many employees feel that their present retirement program is not adequate and, given the choice, will opt for more retirement benefits and less current cash compensation.

In the case of welfare benefits, there is not yet sufficient data to determine whether the net effect of flexible compensation will be to increase or decrease utilization of nontaxable benefits. On the one hand, experience has proven that many employees can be induced to accept lower levels of traditional medical and life insurance coverage if the cost savings are shared with them under a flexible compensation plan. On the other hand, certain of the newer tax-free benefits, such as dependent care and group legal services, usually appeal to only a minority of the workforce. Because flexible compensation plans make it more feasible to target these benefits to the groups that need them, it is possible that flexible compensation will increase the availability and utilization of these non-traditional benefits. At this stage in the development of flexible compensation, no one can accurately predict the net effect on income tax revenues of these conflicting trends.

S. 640

The ECFC's position on S. 640 can best be summed up by quoting from Committee Chairman Dole's recent article in the Washington Post: "[T]ax changes ought to be selected for their own merits in terms of public policy, rather than just random revenue sources. We must justify any revenue increase in terms of sound public policy * * *."

The ECFC agrees wholeheartedly with the Chairman's philosophy and will seek to demonstrate that, while S. 640 may qualify as a "random revenue source", it fails the test of "sound public policy".

ECFC cannot deny that taxing a portion of employer-provided medical benefits will generate some additional tax revenue. Many of our members already are spending more on health benefits than the S. 640 "cap" amounts, and their employees would be taxed on the excess amount unless their medical benefits were cut back. However, a tax on group welfare benefits is a costly and inequitable way for the Government to raise money. In the case of medical insurance, group legal services, day care centers, and other benefits provided on a group basis, the costs of coverage are not allocated to individual employees. Legislation such as S. 640 would force the employer to identify the employees covered by each of the several welfare benefit plans he might offer, allocate the costs of those plans among the employees, compute the part that would exceed the dollar "cap", and include this amount in the employee's W-2 income. Moreover, every month employees would enter and leave each of the plans, and the premiums or costs themselves would change monthly or quarterly. Every such change would require that the allocation of costs be recalculated. The result of this tremendous analytical effort by the employer would be to add, at most, a few dollars to each employee's monthly income.

In short, if revenue must be raised, it would be hard to imagine a measure that accomplished so little at so high a cost to employers as dollar "caps" on group benefits.

HEALTH CARE COST CONTAINMENT

As a measure for controlling health care costs, we believe that S. 640 is not the best approach. Employers are in complete agreement with the Administration that health care costs are too high. Every extra dollar spent on employee health care is a dollar out of the employer's pocket. As a result, employers are already acting in a number of ways to control and reduce costs. Because employers and the federal government have the same objective in reducing the cost of health care, this is one area in which business and government should work together.

The thrust of S. 640 is to place a tax burden on the employee if his employer provides medical coverage above a certain level. The theory is that employees use health care inefficiently because the employer's contribution towards the cost is tax-free. This theory, however, is probably wrong. The typical employee uses health benefits inefficiently because he has no incentive to limit his use of those benefits and he has no incentive to seek out the less expensive providers of health care. It is the problem inherent in any situation in which the cost of the benefit to the individual is not based upon his personal utilization of the benefit. A tax on the employer's contribution towards the benefit does not create an incentive for any single employee to utilize the benefit more efficiently.

At most S. 640 may cause employers to lower benefit levels. Indeed, since the employer already has more than sufficient incentive to find the lowest cost insurance provider for any given level of benefits, the only way the employer can reduce his cost below the "cap" is to reduce the level of benefits. Likely candidates for elimination from the health benefits package would be vision care, dental care, maternity benefits, preventive care, and catastrophic coverage.

No matter how far the employer whittled down the health benefit package in response to S. 640, the incentives for cost escalation would remain. Employees would continue to perceive the scaled-down benefits as costing them nothing and would continue to use them inefficiently. In other words, S. 640 would tend to decrease the amount of health benefits provided by employers while the costs of those diminished benefits continued to escalate. In contrast, sound public policy would favor increasing the amount of coverage and decreasing the cost of that coverage.

FLEXIBLE COMPENSATION AND COST CONTROL

As noted above, employers are well aware that the cost of fringe benefits should be brought down. But S. 640 would tend to reduce benefits, which is not the same as reducing the cost of the benefits. An increasing number of employers are concluding that the goal of decreasing costs while maintaining adequate coverage can best be accomplished through flexible compensation. Under a flexible compensation plan, the employee is offered different levels of coverage. If he elects an economical level of coverage, he can acquire other benefits or a cash rebate. Since the employee must give up something in order to get a more expensive medical plan, he begins to appreciate the high cost of medical coverage. This process of educating employees on medical costs and creating tangible incentives to control costs is the foundation of true health care cost containment.

Flexible compensation plans that offer choices among tax-free benefits (such as medical insurance) and taxable benefits (such as cash) are referred to as "cafeteria plans" and were ratified by Congress when it added section 125 to the Internal Revenue Code in 1978. Section 125 simply states that an employee will be taxed solely on the basis of the benefits that he or she selects and not on the basis of what he or she might have selected instead. To qualify for this result, the cafeteria plan must not discriminate in favor of highly paid employees.

Even though section 125 is five years old and expresses a very simple concept, the Internal Revenue Service has failed to issue any regulations. An employer cannot even obtain a ruling on whether the simplest cafeteria plan qualifies under section 125. In spite of this bureaucratic "foot-dragging", large numbers of employers have gone ahead with the cafeteria plan concept. A principle motivation for these employers has been the need to control the cost of health and other benefits by teaching employees that the cost of fringe benefits ultimately is borne by the employee. Cafeteria plans teach this lesson by making clear what unions and top executives already know: fringe benefits are not an addition to cash compensation, they are an alternative to cash compensation. In a cafeteria plan this message is forcefully delivered. If an employee is willing to accept more economical fringe benefits, his salary will be increased: if the employee insists on high-cost benefits, his salary will be reduced.

Two big advantages of flexible compensation over other tax incentives for controlling benefits costs are that section 125 is already part of the Internal Revenue Code and that programs have already been implemented by numerous employers. The motivation of these employers is the same as this Committee's—to eliminate unnecessary flows of dollars into nontaxable fringe benefits. The ECFC believes that expanding and improving section 125 would be far more effective than imposing fixed dollar "caps" in controlling the cost of health care and other group benefits.

THE FUTURE OF FLEXIBLE COMPENSATION

At a time when American business management has been accused of falling behind the Japanese and other competitors in their ability to motivate and manage the more educated and independent workforce of a modern economy, flexible compensation is one area where this country has taken the lead. In too many instances Americans have taken the lead in some area, then watched others forge ahead while they did battle with Congress, the bureaucracy, and even the courts for permission to implement new ideas.

The ECFC hopes that the common interest of government and business in encouraging more judicious use of welfare benefits by employees will persuade this Committee to continue treating flexible compensation plans no less favorably than welfare benefits plans that do not provide choices. If this Committee or the Treasury perceives any area in which section 125 needs to be clarified or strengthened, the ECFC is eager to cooperate in developing reasonable solutions. In particular, to the extent the Treasury believes that clarifying legislation would facilitate issuance of regulations, we stand ready to provide our advice and support.

EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION

Regular members

Amdahl Corporation; American Can Company; American Express Company; Apple Computer, Inc.; Aramco Services Company; Armco Inc.; Atlantic Richfield Company; Baker Oil Tools, Inc.; Ball Corporation; Bank of America N.A. & S.A.; Blue Bell, Inc.; Comerica, Inc.; Conoco, Inc.; Continental Group; Diamond Shamrock Corporation; Digital Equipment Corporation; Eastman Kodak Company; Educational Testing Service; FMC Corporation; FMR Corporation; Honeywell, Inc.; Hughes Aircraft Co.; Ingersoll-Rand Company; J. C. Penney Company; J. & W. Seligman & Co., Incorporated; LTV Corporation; Marriott Corporation; Mellon National Corporation; Mine Safety Appliances Company; Mobil Corporation; Morgan Guaranty Trust Company of New York; Morgan Stanley & Co.; Newconex Corporation; PepsiCo, Inc.; Pfizer, Inc.; Pitney Bowes Inc.; PQ Corporation; Procter & Gamble; Public Service Electric and Gas Company; Quaker Oats Company; Rhode Island Hospital Trust National Bank; Rouse Company; Sears, Roebuck and Co.; Singer Company; SmithKline Beckman Corporation; Southern California Edison Company; Stouffer Corporation; Sun Company, Inc.; Sybron Corporation; Texaco Inc.; 3M; Time Incorporated; TRW Inc.; Uniroyal, Inc.; Whitehall Group, Inc.; and Xerox Corporation.

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Senator DURENBERGER. Did you have an add-on to that, Mr. Hutchings, or is that your 5 minutes?

Mr. HUTCHINGS. No, sir, this is an even trade.

The CHAIRMAN. Well, it may not be. You are going to have to keep it as short as you can.

Mr. HUTCHINGS. I promise.

STATEMENT OF PETER HUTCHINGS, PARTNER, KWASHA LIPTON, FORT LEE, N.J., ON BEHALF OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, WASHINGTON, D.C.

Mr. HUTCHINGS. My name is Peter Hutchings. I am a consulting actuary practicing in the area of flexible benefits.

Senator DURENBERGER. Oh, I'm sorry. Mr. Chip is a separate panelist. We just took you out of order, right?

Mr. HUTCHINGS. That's right.

Senator DURENBERGER. I apologize. Go right ahead. I thought you were associated here.

Mr. HUTCHINGS. No. I am a consulting actuary practicing in flexible benefits, and I am appearing today representing the Association of Private Pension and Welfare Plans. It is an association with several hundred plan sponsors as well as consulting firms, insurance companies, and so on.

Our prepared remarks address basically two aspects that have apparently been of some concern, one of which is discrimination possibilities in flexible benefits and one of which is pricing.

Taking discrimination first, we support the idea of availability standards for nondiscrimination testing in cafeteria plans. We don't think it would be fair if only the higher paid were permitted to choose some of the benefits; however, we don't support what is sometimes called a utilization test which would attempt to measure the use of benefits by various groups.

If you consider the nature of the decision involved in choosing among health care plans, for example, the employees will pay attention to such considerations as their state of health, presence or absence of coverage through a spouse, their expected use of care. It is basically a health care decision, not an economic decision.

By contrast, the decision to make a contribution into a cash or deferred arrangement under 401(k) is a straight financial decision and is amenable to utilization-type testing.

We think if the actual benefit utilization for one employee or a group turned out to be different, it would not be in any way correct to assume that this signified some kind of discrimination. Age differences, health condition differences, location, patterns in the choice of physicians, are all major contributors to utilization differences of health care. And so we don't think a utilization test makes sense in this area, although we do support an availability test.

Moving on to pricing, there has been some discussion about the need to monitor option pricing within a flexible benefit plan. I guess the concern here is discrimination, in the sense that one benefit would be priced in a more favorable fashion than another.

We think there can be good reasons for one flexible benefit to be priced differently than another. Some employers might choose to subsidize a benefit such as dental in the hopes that they could get substantial employee participation, which would make the dental program work much better.

Other employers might use the subsidy route to encourage employees to move out of traditional coverage into some of the more modern designs that we have heard discussed today. Pricing strategies can help employees go this way.

Even errors in estimating can produce subsidies of one option or another.

On balance, we feel that accidental or intentional pricing subsidies for one benefit versus another can happen and should not be penalized. We think that the option pricing area should be left alone for flexible benefits—it has been left alone for conventional benefits, after all, and if we try to regulate discriminatory pricing we are going to wind up with rules that are hard to draft, harder to understand, and even harder than that to enforce.

Senator **Durenberger**. You wouldn't have the same objection if within a single benefit we required the same subsidy, for example, in health care, if you were going to present three or four health care plans, and we mandated the same subsidy for all those plans, that wouldn't present a problem, would it? You are talking about permitting the varying subsidies as between benefits.

Mr. **Hutchings**. Well, we do anticipate some problems with attempting to measure the subsidy level between even three medical plans. There can be fluctuations depending on which employees choose which plans. The older people might be more attracted to one plan and the younger to another; the employer might have good reason to persuade people to move in the direction of a new plan that had better cost containment and might choose to put more of his own money behind that kind of a program.

We can see a lot of good reasons why employers would use pricing strategy as opposed to simply taking their best shot.

Senator **Durenberger**. I am sorry I interrupted you.

Mr. **Hutchings**. That's quite all right. I was just coming to the summary.

We think flexible benefits will serve America well. They will help the employers in terms of cost control; they can help employees satisfy the unique and increasingly divergent benefit needs. And we think that good availability standards will enable us to make these programs available to benefit employees at large. And we think, for these reasons that I have attempted to present, that utilization standards and pricing standards will not work out nearly as well.

Thank you for the opportunity to testify. My association would be very happy to participate with staff in any further discussions on these areas.

Senator **Durenberger**. Thank you very much.

[The prepared statement of Peter Hutchings follows:]

STATEMENT OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, INC.

Mr. Chairman and Members of the Committee, my name is Peter Hutchings. I am a consulting actuary practicing in the area of flexible benefits. I appear before you today representing the Association of Private Pension and Welfare Plans, Inc.

Our Association includes several hundred plan sponsors of all sizes as well as a number of consulting firms, insurance companies, banks, accounting firms, and others associated with employee benefit plans. The Association's interests cover the entire range of employee benefit questions.

My prepared remarks today will focus on regulatory aspects of cafeteria benefits, also known as flexible benefits. We strongly believe that flexible benefit plans are the most efficient means of providing benefits for today's changing workforce and that action must be taken now to provide the necessary guidance and encouragement to plan sponsors which wish to adopt or currently maintain flexible benefit plans.

Over the years, Congress has granted favorable tax status to a number of socially useful employee benefits. For example, plan sponsors can now provide life and health programs, dependent care, disability income benefits and group legal services on a tax-favored basis.

In 1978, Congress recognized that it no longer made sense to force employers to provide identical benefit programs for each employee. Section 125 was enacted to permit employers to offer programs which allowed choice between taxable and nontaxable benefits. The modern American workforce is considerably more varied today than it was only ten or fifteen years ago. Two-earner families and women heads of households are particularly likely to have unique benefit needs, and these are just the type of employees whose participation in the workforce is growing.

When both spouses are wage-earners, it is wasteful for each of their employers to provide health benefits for the family. Similarly, many single people do not need much life insurance. On the other hand, working women with children at home need dependent care.

Flexible benefit programs enable employees to trade unneeded benefits in one area for cash, or for extra benefits in another area. A good number of the programs in existence today allow additional benefits to be bought through salary reduction or salary conversion. As a result, employers can make much broader programs available on a cost-effective and tax-effective basis.

Perhaps because of these advantages, the growth of flexible benefits programs has accelerated in the past year. Large and small organizations have moved into flexible benefits, some cautiously and incrementally and others all at once. Other plan sponsors have taken a wait and see attitude. For this latter group, the total lack of proposed or final regulations for Section 125 is the biggest hinderance to plan adoption.

We understand from public statements and conversations with representatives of the Treasury Department that regulations have not been developed because of concerns which center on discrimination standards and the pricing of benefits.

Today, flexible benefit programs must meet certain nondiscrimination standards for the cafeteria plan as well as somewhat different standards for each of the specific benefits. These standards are intended to make sure the programs benefit employers generally and not just the higher paid. We believe that a single uniform standard can be developed as to eligibility for benefits. Such a single standard would make it easier to establish these type of plans.

We support the use of availability standards for nondiscrimination testing. It would not be fair for a cafeteria plan to make some benefits available only to the higher paid.

On the other hand, with the exception for a § 401(k) plan, we do not feel that it would be appropriate to apply a utilization of benefits test for cafeteria plans. For example, consider the nature of the decision the employee is making in selecting health coverage and deciding how much salary redirection to make to supplement this coverage. It is a decision based on the individual's health, not a tax decision. Employees who anticipate needing coverage will utilize the program more heavily; employees already covered through a spouse's plan or employees confident of their well-being may select a less expensive plan and may be expected to utilize its benefits at a lower level. In any case, their decisions will be triggered by their health needs not their tax bracket.

By contrast, an employee who redirects $100 a month into a § 401(k) cash or deferred arrangement is making a financial decision. To ensure that such a program benefits employees generally, we may reasonably ask the plan sponsor to measure the actual utilization of the plan by the lower paid. Just such a test is now in place for § 401(k).

If we try to adapt the § 401(k) test to benefits such as health, life and disability under a flexible benefit program, serious problems can be anticipated. Substantial uncertainty exists in predicting the extent to which one employee or a group of employees will draw benefits out of any one of these programs. Furthermore, even where the actual benefit utilization is different for one employee segment than another, it is not necessarily correct to assume that discrimination is at work. Age differences, health condition differences, patterns in choice of physicians or even geographic location differences are major sources of group variations in cost of health care.

In writing regulations for self-insured medical plans, the Treasury has already decided that "a plan is not discriminatory merely because highly compensated individuals participating in the plan utilize a broad range of plan benefits to a greater extent than do other employees participating in the plan." (Income Tax Regulation § 1.105–11(c)(3)(ii).) We agree with this approach to conventional plans, and urge that the new flexible benefit programs be treated on the same reasonable basis as existing conventional programs.

As we indicated earlier, another area of discussion has been the possibility of abusive pricing in flexible benefit plans. The pricing of a cafeteria plan is more complex than a conventional plan both because of the number of options involved and because of the tendency for employees to exercise intelligent selection—that is, to add benefits they plan to use and to downstep or drop benefits they do not expect to use.

There can be good reasons for one flexible benefit option to be priced on a different basis than another. For example, some employers might choose to underprice, or subsidize, a new benefit such as dental care to get a broad cross-section of employees into the plan. Cost problems can arise if the dental plan's participation is limited to a small group of high users. These problems can be moderated by a pricing strategy that knowingly subsidizes the dental option.

Other employers might use the pricing process to encourage employees to move out of an existing traditional paid-in-full health benefit design into a program with cost-sharing features designed to control benefit costs. Pricing strategies can help encourage employees to change by supporting the new option with extra employer funding. Many feel that one of the key contributions that flexible benefits will make is to facilitate just this type of benefit conversion into more efficient health care programs.

Even simple errors in estimating can produce subsides of one option versus another, since accurate predictions of the costs of these benefits is very difficult. We feel that accidental or intentional pricing subsidies for one benefit versus another benefit can happen and should not be penalized.

We understand that there has been some concern expressed about the possibility that the employer decisionmaker would knowingly underprice an option he was planning to use personally. Conventional group health benefits on a tax-favored basis have been part of the scene for decades. Employer decision-makers who put in a particular benefit to help themselves will also help the rank and file, and hence there are no elaborate Federal regulations in this area for conventional plans. Similarly, an employer decision-maker who underprices a flexible benefit option will make that same bargain available to his employees.

On this basis, we urge that the option pricing area be left alone for flexible benefits just as it has been left alone for conventional benefits. Our strong feeling is that discriminatory pricing rules will inevitably be difficult to draft, more difficult to understand, and yet more difficult to enforce.

In summary, we believe flexible benefits will serve America well. These programs can help employers control costs. They can help employees satisfy their unique and increasingly divergent benefit needs.

Employers who feel this way see flexible benefits as an opportunity to reassess their plan design in light of the realities of the 1980's. These reassessments not infrequently result in the injection of increased deductibles, coinsurance or employee contributions into the health benefit. These changes are designed to increase employee involvement in the costs of his benefits, and to get away from the first dollar coverage mentally.

We believe that the Federal Government should continue to ensure that these programs fulfill their purpose of benefitting employees generally. We strongly recommend that availability standards rather than utilization standards be relied upon. And we feel that a good availability standard will preclude the need for direct or indirect pricing regulation.

Thank you for the opportunity to testify today. As the Committee considers the area of flexible benefit plans, we hope that we can be of assistance to you and your staff in the development of the proper environment to encourage the use of such plans.

STATEMENT OF DALLAS L. SALISBURY, EXECUTIVE DIRECTOR, AND DEBORAH CHOLLET, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, D.C.

Senator DURENBERGER. Dallas, we welcome you back again.

Mr. SALISBURY. Good to see you, sir.

Senator, as you know, the institute has documented in recent submissions the maturing of the Nation's employee benefit programs and their growing success in meeting the economic security needs of the Nation's working and retired populations.

The growth of employee benefits as a form of employee compensation has attracted increasing attention in recent years. In the 1960's and 1970's this concern centered around perceived inadequacies in funding and coverage. That concern over coverage was continued in your hearings this Monday and Tuesday.

Laws were passed which mandated that certain things be done, which on a mandatory basis increased the flow of money into employee benefit programs.

Beginning in 1982, concern over Federal budget deficits and tax subsidies has caused concern that the growth of benefits occurs at the expense of the tax base.

Our detailed statement quantitatively looks at two issues:

The first is the fact that erosion of the tax base by employee benefits has been much more limited than is commonly perceived. According to chamber of commerce data, employer contributions to employee benefits totaled about 32 percent of wages and salaries in 1981. In recent statements by members of the Administration and Congress, they have referenced 30 to 50 percent of pay going to employee benefits and reducing taxes.

It is worth noting that of that 32 percent over three-fourths, or 23.7 percent, of wages and salaries represents either legally required employer payments or discretionary employer payments that are fully taxable.

Employer contributions to tax-favored benefits that are not taxed as current income can be broken into two categories: tax-deferred benefits, which include primarily employer contributions to retirement income and capital accumulation plans, which constituted only 3.4 percent of total compensation in 1981; and tax-exempt benefits, including employer contributions to group health and group life insurance—that is, benefits where there is never a regaining of income to the Treasury—constituted 3.5 percent of total compensation in 1981.

This combined total of only 6.9 percent of total compensation is far below the types of numbers that are frequently used when focusing on the tax subsidies of the Code.

Failure to distinguish, we would suggest, among the growth of legally required employer payments, fully taxable employee benefits, tax-deferred benefits, and tax-exempt benefits has greatly magnified the perception of the tax base erosion that can be attributed to employee benefits that are offered on a voluntary basis.

Second, the analysis to date of a tax cap on health care, according to our analysis, has grossly overstated perceived revenue gains, misconstrued the effects at different earnings levels, and largely ignored likely coverage losses that would take place for the neediest segments of the workforce.

Four issues are reviewed in the testimony that assess the success of the health tax cap proposals: Changes in the generosity of coverage provided by employer group plans has not been full researched; in spite of the fact that some claim to know what the answer will be, it is not yet fully documented.

Changes in employer costs have been looked at. They have been discussed in the context of the Treasury estimates. We'll simply note in the terms of the Treasury estimates—that has been stated by representatives of the Congressional Budget Office, and others, including the witness this morning—the assessment is based on an assumption that there will be no change in behavior as a result of a tax cap.

Impact in terms of burden is another important issue. And as the statement fully documents, we have concerns that among households that would be affected by a cap of the exclusion of employer contributions to health insurance, the tax burden would be severely regressive.

This morning, contrary to prior administration testimony on other tax measures, we heard that it would in fact cost higher income people much more. It depends on how you look at it. As a percentage increase in the taxes paid it would represent a significantly greater tax increase for lower income people than for higher income people. Only in absolute dollars would it cost more for higher income people.

Employers and employees, in summary, place a high value on employee benefits. Many benefits such as time off are fully taxed; they represent 15 percent of current compensation and are a major portion of what Senators and others commonly refer to as employee benefits.

The Government has encouraged the growth of other benefits through tax incentives. Past concern over low rates of private health insurance and pension coverage among workers, even with tax incentives, has led to discussions of national health insurance and mandatory private pensions.

Now, concern over deficits is leading to proposals that could have the effect of reducing coverage in these tax-favored programs which provide vital economic security to our working and retired populations.

We must not lose sight of the usefulness of employee benefit programs in accommodating the dramatic demographic changes now taking place in the workforce, of which you heard much on Monday and Tuesday of this week.

You heard about the changing nature of women's attachment to the workforce, the tremendous growth in the number of two-worker families, single-parent households, and other demographic changes.

We suggest that in looking at section 125 of the Code and the issue of flexible compensation we not lose sight of the degree to which such flexibility might be the most effective means available to this economy for accommodating this changing workforce.

Indeed, I would have suggested to many at the hearings earlier this week that flexible compensation might become the most important women's employee benefit issue of the decade, once it is focused upon.

We thank you for the opportunity to appear today. We stand ready to assist the committee in analysis in these areas, and we recommend to you the full statement as well as the research that it reports upon.

Senator DURENBERGER. Thank you very much for your testimony.

[The prepared statement of Dallas Salisbury follows:]

STATEMENT OF DALLAS L. SALISBURY, EXECUTIVE DIRECTOR AND DEBORAH CHOLLET, PH.D., RESEARCH ASSOCIATE

Mr. Chairman, it is a pleasure to appear before you today. I am Dallas Salisbury, Executive Director of the Employee Benefit Research Institute. With me is Deborah Chollet, a Research Associate EBRI. EBRI is a nonprofit, nonpartisan, public policy research organization founded in 1978. EBRI sponsors research and educational programs in an effort to provide a sound information basis for policy decisions. EBRI does not take positions on public policy issues.

We are pleased to address the Committee concerning the taxation of employee benefits.

Introduction

The growth of employee benefits as a form of employee compensation has attracted increasing attention in recent years. Attention has intensified because of a concern that the growth of benefits occurs at the expense of growth in wage and salary income. Slower growth of wage and salary increase, in turn, implies slower growth of the tax base. Erosion of the tax base affects the public sector's ability to finance government programs in general, and the Social Security system in particular. In addition, growth of nontaxable benefits may imply an important redistribution of tax burden across the population. These effects of growth in employee benefits, and in tax-exempt benefits in particular, certainly merit careful attention from the Congress. EBRI is pleased to provide information that will assist the Congress in valuating the consequences of emplloyee benefit growth. First, our testimony deals with the broad issue of employee benefits and erosion of the tax base. Second, it reviews the results of recently completed EBRI research on proposals for a tax cap on employer contributions health insurance.

The Composition of Employee Benefits

Possibly the most often-quoted figures on the level and growth of employee benefits are compiled by the Chamber of Commerce of the United States. The figures are based on annual survey responses by a small number of employers (fewer than 1000); the employer sample is not scientifically selected, nor is it weighted to be representative of true national totals. Nevertheless, estimates based on these data capture a picture of the general distribution of employee benefits among (1) legally required employer payments, (2) fully taxable employee benefits and (3) tax-favored employee benefits. Disaggregating the total level of employee contributions reported in the Chamber of Commerce data among these three groups clarifies the magnitude of tax-base erosion that can be attributed to the growth of employee benefits.

According to the Chamber of Commerce data, employer contributions to employee benefits totaled more than 32 percent of wages and salaries in 1981. Nearly three-fourths (23.7 percent of wages and salaries) of this figure represent either legally required employer payments (9.6 percent of wages and salaries) or discretionary employer payments (14.1 percent of wages and salaries) that are fully taxable (See Table 1). Legally required employer payments include contributions for FICA, unemployment compensation insurance, workers compensation insurance, and a variety of smaller public insurance programs.

Discretionary employer contributions to benefits in the Chamber of Commerce data represented 22.9 percent of wages and salaries in 1981. Of this amount, nearly two-thirds (60.3 percent) were fully taxable both by FICA

TABLE 1

COMPOSITION OF EMPLOYEE BENEFITS BY BENEFIT GROUP, 1981

Benefit Group	Employer Payments as a Percent of Wages and Salaries	Employer Payments as a Percent of All Benefits
Total benefit payments	32.5	100.0
Legally required employer payments	9.6	29.5
FICA	5.3	16.3
Unemployment Compensation	1.0	3.1
Workers' Compensation	0.9	2.8
Other legally required payments 1/	2.4	7.4
Discretionary taxable benefits	14.1	43.4
Time not worked 2/	10.0	30.8
Rest priods	3.8	11.7
Other taxable benefits 3/	0.3	0.9
Discretionary tax-favored benefits	8.8	27.1
Contributions to pension ans profit-sharing plans 4/	3.9	12.0
Group healt, life, short-term disability insurance	4.2	12.9
Other tax-favored benefits 5/	0.7	2.2
SUMMARY:		
Legally required employer payments and discretionary taxable benefits	23.7	72.9
All discretionary benefits	22.9	70.5
Fully taxable benefits	14.1	43.4
Tax-favored benefits	8.8	27.1

SOURCE: EBRI tabulations of estimates produced by the Chamber of Commerce of the United States. Chamber of Commerce of the U.S., Employee Benefits 1981 (1982), pp. 8 and 30.

1/ Includes government employee retirement, Railroad Retirement Tax, Railroad Unemployment and Cash Sickness Insurance and state sickness benefits insurance.

2/ Includes paid vacations and payments in lieu of vacation; payments for holidays not worked; paid sick leave; payments for State or National Guard Duty; jury, witness and voting pay allowances; and payments for time lost due to death in family or other personal reasons.

3/ EBRI estimate based on Chamber of Commerce report of amount of Christmas or other special bonuses, service awards, suggestions awards, special wage payments ordered by courts, and payments to union stewards.

4/ EBRI estimate of Chamber of Commerce report of employer contributions to profit-sharing plans.

5/ EBRI estimate of Chamber of Commerce report of employer-paid dental premiums, merchandise discounts, employee meals furnished by company, payments for vision care and prescription drugs, moving expenses, contributions to employee thrift plans and employee education expenditures. Tax-preferred benefits are over-stated by the amount of separation or termination pay received by employees but not distinguishable from other tax-favored benefits in the Chamber of Commerce estimates.

and by the individual income tax. The fully taxable benefits reported in the Chamber of Commerce data include employer payments for time not worked (that is, paid vacations, holidays and sick leave) as well as paid rest periods, lunch periods and other paid employee time not directly spent in production. Less than one-third (27.1 percent) of the total level of employee benefits reported in the Chamber of Commerce data represent discretionary tax-favored benefits paid by employers. Tax-favored benefits totalled only 8.8 percent of wages and salaries in 1981, and about 8.5 percent of total compensation.

The Size of Tax-Favored Benefits

Employer contributions to tax-favored benefits that are not taxed as current income to the employee can be divided into two groups: benefits on which taxes are deferred and benefits that are tax-exempt.

- o Tax-deferred benefits include, primarily, employer contributions to retirement income and capital accumulation plans. These constituted about 5.4 percent of total compensation in 1981. Taxation of these benefits is deferred until the employee withdraws funds from the plan.
- o Tax-exempt benefits include employer contributions to group health and life insurance, long-term and short-term disability income insurance, and a variety of smaller benefits that include dental insurance, child care, merchandise discounts and employer-provided meals. These benefits constituted 3.5 percent of total compensation in 1981. 1/

Failure to distinguish among the growth of legally required employer payments, fully taxable employee benefits, tax-deferred benefits and tax-exempt benefits has greatly magnified the perception of the tax-base erosion that can be attributed to tax-favored and tax-exempt benefits. This common misperception was recently highlighted by Secretary of the Treasury Donald Regan; his May 22, 1983 statement to ABC News includes the following comment:

> I think that when you look at the way our pension systems, our medical systems and the like are just running at full throttle, and are increasing year after year, that sooner or later they're going to have

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1/ National Income and Product Accounts, U.S. Department of Commerce.

to be slowed down or else we'll never get these deficits under control. 2/

The magnitude of tax-favored benefits as a proportion of total compensation however, is much smaller at 8.8 percent of wages and salaries than such statements suggest. Tax-exempt employee benefits are only 4.7 percent of wages and salaries; benefits on which taxes are deferred but ultimately paid are 4.1 percent. The distribution of tax-favored benefits between those that are tax-deferred versus those which are entirely tax-exempt is summarized in Table 2.

The Growth of Tax-Favored Employee Benefits

Tax-favored employee benefits have grown more rapidly than wages and salaries, and slightly faster than either legally required employer payments or fully taxable employee benefits over the last thirty years. Consequently, tax-favored benefits have absorbed a rising share of total compensation. In the context of strong and increasing tax incentives for employees to demand a greater share of compensation in the form of tax-deferred or tax-exempt benefits, however, the growth of these benefits as a share of total compensation has been remarkably slow.

The national income and product accounts compiled by othe U.S. Department of Commerce indicate that employer contributions to major tax-preferred benefits as a fraction of total compensation increased at an average annual rate of 4.4 percent between 1950 and 1981. The long-term growth of tax-preferred benefits relative to total compensation growth is presented in Table 3. Although the growth of tax-favored employee benefits

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2/ "This week with David Brinkley," Show #82, Transcript (May 22, 1983) produced by Journal Graphics, Inc. New York, N.Y., p. 8.

TABLE 2

TAX-FAVORED EMPLOYEE BENEFITS BY SPECIFIC TAX TREATMENT, 1981

Tax Status/ Benefit Group	Employer Contributions As a Percent of Wages and Salaries	Employer Contributions As a Percent of All Benefits	Employer Contributions As a Percent of Tax-Favored Benefits
All tax-favored benefits	8.8	27.1	100.0
Tax-deferred benefits	4.1	12.6	46.6
Pension and Profit-sharing plans 1/	3.9	12.0	44.3
Other tax-deferred benefits 2/	0.2	0.6	2.3
Tax-exempt benefits	4.7	14.5	53.4
Contributions to group health and life insurance, and short-term and long-term and disability income insurance	4.2	12.9	47.7
Other tax-exempt benefits 3/	0.5	1.5	5.7

SOURCE: EBRI tabulations of estimates produced by the Chamber of Commerce of the United States. Chamber of Commerce of the U.S., Employee Benefits 1981 (1982), pp. 8 and 30.

1/ Includes EBRI estimate of employer contributions to profit-sharing plans based on Chamber of Commerce figures.

2/ Includes EBRI estimate of employer contributions to employee thrift plans based on Chamber of Commerce figures.

3/ EBRI estimate of employer contributions to dental insurance premiums, discounts on merchandise, employee meals furnished by company, payments for vision care and prescription drugs, moving expenses, and employee education expenditures, based on Chamber of Commerce figures.

TABLE 3

EMPLOYER CONTRIBUTIONS TO PENSION AND SELECTED WELFARE FUNDS AS A PERCENT OF COMPENSATION, SELECTED YEARS 1950-1981, AND AVERAGE ANNUAL RATES OF GROWTH

	Total	Pension and Profit-Sharing Plans	Group Health	Group Life
1950	1.8	1.1	0.7 1/	-
1955	2.5	1.5	0.8	0.2
1960	3.1	1.6	1.1	0.4
1965	3.8	1.9	1.5	0.4
1970	4.5	2.1	1.9	0.5
1975	6.2	3.0	2.7	0.5
1976	6.4	3.2	2.8	0.4
1977	6.7	3.3	3.0	0.4
1978	6.8	3.4	3.0	0.4
1979	6.8	3.4	3.0	0.4
1980	6.9	3.4	3.1	0.4
1981	6.9	3.4	3.1	0.4
Average Annual Growth Rates:				
1950-1981	4.4	3.7	4.9	2.3
1970-1981	4.0	4.5	4.6	-2.0
1970-1975	6.6	7.4	7.3	-
1976-1981	1.5	1.2	2.1	-

SOURCE: National Income and Product Accounts, U.S. Department of Commerce.

1/ Includes both group health and group life for this year.

relative to total compensation was strong between 1970 and 1975, (6.6 percent per year), it slowed dramatically between 1976 and 1981 to just 1.5 percent. Growth between 1970 and 1975 reflects several factors: the slow growth of wages both before and during economic recession, employer efforts to improve pension funding in anticipation of and response to ERISA, net growth in pension and health plan participation, and sudden increases in the employer cost of group health insurance benefits. The relatively slow growth of employer pension contributions relative to total compensation growth between 1976 and 1981 reflected employer adjustment to ERISA as well as employee demand for higher nominal wage compensation in response to slow real wage growth. The slower growth of employer health insurance contributions as a share of total compensation may reflect the maturation of group health coverage and benefits, as well as employer efforts to contain the cost of private health insurance plans.

Estimates of Tax Base Erosion

The debate over Social Security Reform focused in part on the issue of tax base erosion. The revenue-enhancement debate also involves this issue. Estimates of future tax-base erosion that can be attributed to the growth of employee benefits, however, have been misleading for two reasons.

First, these estimates fail to recognize the factors that affect the growth of tax-favored benefits relative to total compensation. In general, higher pension contributions as s proportion of compensation reflect greater participation in employer pension plans. Employer contributions to defined-benefit pension plans move directly with wages; as a matter of actuarial practice, employers target pension contributions to be a constant proportion of compensation. Employer contributions to health insurance, however, are independent of wages. As a result, slow wage growth together with higher rates of health care cost inflation always produce a jump in employer contributions to health insurance coverage as a percent of total compensation. Employer contributions to group life insurance and disability income insurance also have little relationship to near-term changes in wage growth.

In contrast to tax-favored benefits, both legally required employer payments and fully taxable discretionary benefits automatically grow with wages. In the absence of a statutory change in the required rate of employer contributions to social insurance programs, legally required payments are uniformly defined as a proportion of wage and salary income. The value of fully taxable discretionary benefits -- primarily employer payments for time not worked -- is defined at the employee's wage. The fact that employer contributions to pension and insurance benefits are not fixed relative to wages makes the growth of tax-favored benefits as a share of total compensation rise during periods of slow wage growth and fall as wage growth accelerates. The straight-line estimates of tax-favored wage growth relative to total compensation incorporated in Social Security's projections fail to reflect sources of variation in tax-favored benefit growth relative to total compensation, and the dramatic slowing of this growth during recent years.

Second, estimates of tax-base erosion that results from the growth of tax-favored benefits fail to distinguish between tax-deferred benefits and tax-exempt benefits. Although this distinction may not assist projections of the FICA tax base, it is an important distinction with respect to general revenues. Employer contributions to private pensions, profit-sharing plans and employee thrift plans do not represent total forfeitures of potential revenues. Estimates of tax expenditures attributable to the deferral of taxes on employer pension contributions recognize this by subtracting out revenues from the taxation of pension benefits received by current retirees. It is likely, however, that these estimates exaggerate the long-term tax revenues that are foregone in the tax-deferral of employer pension contributions. 3/

Tax-Favored Benefits: Goals, Achievements and Tax Effects

Employee benefits serve a number of purposes. Pensions, profit-sharing plans and employee thrift plans provide for income deferral and encourage private saving for retirement. Health benefits, disability income plans, life insurance and supplemental unemployment benefits provide insurance protection against unanticipated, catastrophic events. Some profits provide for consumption; these include day-care benefits and, possibly, routine dental and vision care benefits. Many of these consumption benefits, together with employee vacation time and rest periods, are intended to raise employee productivity, reduce time lost from work and build positive employee relations.

The expansion of employer pension and welfare plans over the last thirty years have achieved major improvements in the income security of current workers and future retirees. Growth of employer group health insurance coverage among workers and their dependents has promoted wide

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3/ The calculation of tax expenditures exaggerates the true revenue loss that results from the tax deferral of pension contributions for several reasons. These include an implicit assumption about the marginal tax rates applicable to future retirees as well as a misunderstanding of the relationship between contributions and benefit payments in amaturing private pension system. See: Employee Benefit Research Institute, "Retirement Program Tax Expenditures: A Case of Unsubstantiated, Undocumented, Arbitrary Numbers." EBRI Issue Brief, Number 17 (April 1983), p. 4.

access to health care throughout the nonelderly population. These achievements are, in part, a response to tax incentives.

Between 1950 and 1979, the rate of worker participation in employer pension plans grew by 23 percent; participation in absolute numbers rose by 263 percent. 4/ Although the sustained growth of pension participation rates was interrupted by the passage of ERISA, recent data suggest that the post-ERISA contraction of pension participation rates was a temporary phenomenon. Between 1977 and 1979, the rate of worker participation in private pension plans showed modest growth, an achievement that is particularly remarkable in terms of the accelerated labor force growth that occurred during that period.

In 1979, more that 68 percent of private-sector, n onagricutlural workers between the ages of 25 and 64 were covered by an employer pension plan. 5/ At current coverage rates, 73 percent of current workers aged 25 to 29 can expect to receive a private pension when they retire. 6/ Recent econometric studies indicate that at least one third of the increases in pension contributions as a proportion of total compensation over the last twenty years can be attributed to changes in real marginal tax rates. 7/ Given the growing importance of the private pension system in providing

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4/ S. J. Schieber and P. M. George, Retirement Income Opportunties in an Aging America: Coverage and Benefit Entitlement (Washington, D.C.: Employee Benefit Research Institute, 1981), pp. 54-55.

5/ Op. cit., p. 41.

6/ Background Analysis of the Potential Effects of Minimum Universal Pension System developed by ICF, Incorporated, for the President's Commission on Pension Policy and the Office of Pension and Welfare Benefit Programs (Washington, D.C., 1981), p. 38.

7/ See: Sophie M. Korczyk, The Federal Tax Treatment of Pensions and Deferred Compensation Programs: Background, Issues and Options (Washington, D.C.: Employee Benefit Research Institute, forthcoming).

retirement income security for most Americans, the tax-deferral of pension contributions until retirement appears to be a reasonable, equitable and effective incentive for private retirement saving. The reduction or elimination of this incentive would threaten the adequacy of private pension income for future retirees at the very time that Social Security will be least capable of expanding benefits. Further, the long-term revenue loss associated with the tax-deferral of employer contributions to pensions may be negligible: The marginal tax rates affecting future retirees are likely to be significantly higher than those affecting current retirees. In addition, as the private pension system is maturing, the mix of workers and beneficiaries is beginning to change. 8/

By comparison to the impact of tax-deferring pension contributions, the tax exemption of employer contributions to health insurance has probably had a much smaller effect on the growth of employer spending for health insurance. Recent econometric estimates suggest that the tax exemption of employer contributions may have accounted for only about 17 percent of the rise in health insurance contributions as a share of compensation between 1960 and 1981. 9/

The rapid growth of employer contributions to health insurance as a share of total compensation is attributable to at least three sources:

- expansion of health insurance coverage rates among workers and their dependents, including the growth of family coverage and the extension of health insurance benefits to part-time and seasonal workers;

8/ Employee Benefit Research Institute, "Retirement Program Tax Expenditures: A Case of Unsubstantiated, Undocumented, Arbitrary Numbers," EBRI Issue Bried, Number 17 (April 1983), p. 4.

9/ See: Deborah J. Chollet, Employer-Privided Health Benefits: Coverage, Provisions and Policy Issues (Washington, D.C.: Empoloyee Benefit Research Institute, forthcoming).

- the enhancement of benefits, including expansion of the range of health care services covered by employer group plans;

and

- increases in the cost of health insurance as a result of inflation in health care costs.

The relative importance of these factors in raising employer contributions to health insurance over time cannot be established from available data. Similarly, the effect of the tax exemption of health insurance contributions on coverage rates, benefit enhancement, and employer willingness to absorb health care cost inflation has not been established.

Employer-Provided Health Insurance Coverage and Benefit Growth

The 1980 Current Population Survey indicates that more than 60 percent of the civilian population was covered by an employer group health plan during 1979. 10/ Three quarters of all workers, and nearly 90 percent of full-time full-year workers, participated in an employer group health plan that year. Although it is clear that coverage rates have expanded rapidly over the last thirty years, the absence of time-series data on employer health coverage rates precludes the measurement of its relative importance.

Several factors have encouraged the expansion of employeer group health insurance among workers and their dependents. Scale economies associated with greater inclusion of employees in the insurance group have

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10/ Detail on 1979 employer group health coverage is supported by EBRI tabulations of the March 1980 Current Population Survey. See: Deborah J. Chollet, Employer-Provided Health Benefeits: Coverage, Provisions and Policy Issues (Washington, D.C.: Emploee Benefit Research Institute, forthcoming), Chapter 1.

encouraged the extension of health insurance coverage to lower income workers. The growth of real marginal tax rates since 1960, moreover, has probably increased the demand for employer-provided health insurance. At the same time, the absorbtion of preferred risks into emplolyer group plans has raised the cost of individually purchased health insurance relative to the pre-tax value of employer group coverage.

All of these factors have served to raise the rate of health insurance coverage provided through employer group plans. In 19797, more than 83 percent of all persons with private health insurance were covered by an employer group plan.

The expansion of health insurance benefits offered by employer group plans and employer willingness to absorb health care cost inflation have become highly controversial elements in the debate to reform the tax treatment of health insurance. Critics of current tax policy reform contend that the "generosity" of employer group coverage and the insensitivity of employer plan benefits to rising costs encourages continued inflation in health care costs.

Health insurance benefits in the United States, on average, have traditionally been generous. This has been in part a response to the historical precedent of Blue Cross/Blue Shield plans. First-dollar coverage of hospital care, in particular, has been a common feature of employer group health plans. Expansion in health insurance benefits to include a broader variety of health care services, however, has occurred largely as an attempt by employers to control the cost of their health plans. Coverage of alternative health care services is often intended to discourage hospitalization when an equivalent service can be delivered in a less costly setting.

Although employers have been reluctant to reduce health insurance benefits for their employees, their success in containing the real cost of health insurance benefits by revising coverage offered under the plan has been considerable. Between 1965 and 1981, real employer contributions to health insurance as a percent of compensation fell at an average annual rate of more than 7 percent (see Table 4). Between 1975 and 1981, real employer contributions to health insurance as a share of compensation fell at an average annual rate of nearly 8 percent. The decline of real employer contributions to health insurance during a period of expanding participation in employer group plans suggests that these plans have not simply absorbed inflation in health care costs. Employees have borne at least part of the burden of inflation through reductions in the real value of employer-provided health insurance. Although data that would directly reflect changing coverage provisions in response to health care cost increases are not available, the significant decline in real employer contributions suggests that modification of the coverage offered by employer group plans has occurred.

Proposals to Reform Tax Preferences for Health Insurance

Proposals that would modify the tax exemption for health insurance expenditures are of two types: those that would place a ceiling on the exemption of employer health insurance contributions in order to discourage comprehensive coverage under employer group plans, and those that eliminate all tax preferences for employer health insurance contributions within the framework of comprehensive tax reform. The first type, those that "cap" the exemption of employer contributions, would inpute all employer health insurance contributions in excess of a specified cap as employee earnings.

TABLE 4

INFLATIONARY AND REAL COMPONENTS OF EMPLOYER CONTRIBUTIONS TO GROUP HEALTH INSURANCE BENEFITS, SELECTED YEARS 1960-1981

	Nominal Employer Contributions as a Percent of Compensation	Inflation Adjustment as a Percent of Compensation 1/		Real Benefits and Insurance as a Percent of Compensation	
		Amount	Percent of Contribution	Amount	Percent of Contribution
1960	1.1	-	-	1.1	100.0 2/
1965	1.5	0.2	13.3	1.3	86.7
1970	1.9	0.7	36.8	1.2	63.2
1975	2.7	1.4	51.9	1.3	48.1
1976	2.8	1.6	57.1	1.2	42.9
1977	3.0	1.8	60.0	1.2	30.0
1978	3.0	1.9	63.3	1.1	36.7
1979	3.0	2.1	70.0	0.9	30.0
1980	3.1	2.2	71.0	0.9	29.0
1981	3.1	2.3	74.2	0.8	25.8
Average Annual Growth					
1965-1981	4.6	16.5	11.3	-3.0	-7.3
1970-1981	4.6	11.1	6.6	-3.6	-7.8
1975-1981	2.3	8.6	6.1	-7.8	-9.9

SOURCE: EBRI estimates from the National Income and Product Accounts, U.S. Department of Commerce.

1/ Estimate is based on levels of the medical care component of the Consumer Price Index between 1960 and 1981.

2/ Because base prices are assumed at the 1960 level, all employer contributions to health insurance are allocated to real benefits for 1960.

Contributions above the cap would be fully taxable by both the individual income tax and FICA. In the case of S. 640, the amount of the cap varies for individual versus family coverage, and is adjusted annually by the Consumer Price Index. Proposals of the second type, those which eliminate all federal tax preferences for employer health insurance contributions, include the Bradley-Gephardt comprehensive tax reform bill (S. 1421/H.R. 3271). The Bradley-Gephardt bill requires that all employer health insurance contributions be imputed as employee earnings, and at the same time raises the idividual income tax floor for deducting health insurance expenditures to 10 percent of adjusted gross income.

The difference between proposals that would modify tax preferences for employer health insurance contributions and those that would eliminate them altogether is probably in the magnitude of effects rather than in the nature of effects. The effects of these proposals fall into four categories: (1) changes in the generosity of coverage provided by employer group plans, (2) changes in employer costs, (3) changes in the rate of health insurance coverage among workers and their dependends, and (4) tax revenues and the distribution of the tax burden. Each of these effects is discussed in turn.

(i) Impact on the generosity of health insurance coverage.

The most common argument used argument for reducing or eliminating tax preferences for employer contributions to health insurance is the potential effect on the generosity of coverage offered by employer group plans. Advocates of reduced tax preferences cite the scarce literature on the relationship between insurance prices and the degree of cost-sharing demanded by consumers, and the relatively abundant literature on the relationship between greater cost-shariang and lover health care costs.

Based on this literature, they suggest that tax-exempt employer contributions encourage coverage with little cost-sharing and consequently, greater utilization of health care services, removal of tax exemptions, they conclude, will encourage less comprehensive coverage and lower utilization levels. Lower levels of health care utilization will, in turn, reduce aggregate health care costs and ultimately dampen inflation in health care prices.

Opponents of reduced tax preferences for employer health insurance contributions claim that this argument ignores the complexity of consumer demand for health insurance in an interdependent, multi-product market. They argue that rational consumers are unlikely to reduce coverage for the particular service category -- hospital care -- that drives health care cost inflation. Other service categories -- primary physician coverage, preventive service coverage, and routine dental and vision care coverage -- are more vulnerablethan hospital coverage to tax polity that would incrase the price of health insurance to consumers. The cost of these services, however, has been remarkably stable relative to the cost of hospital care. They conclude that tax policy, if at all successful, is likely to be an inefficient way to contain further inflation in health care costs.

These arguments have not been satisfactorily resolved; neither position is based on a substantial body of research. In seeking to break the deadlock, other arguments that might support the revision of tax preference for employer health insurance contributions must be considered. These include the impact of taxation on:

- employer costs;

- rates of health insurance coverage among worker households; and

- federal revenues and tax burden.

(ii) Impact on Employer Costs.

Employer group health plans, as a rule, cover most if not all employees of the firm. In spite of potentially wide variation in the health care risks represented by different employees, broad participation in the plan is achieved by keeping the price of coverage to employees low. Merged survey data on employer plan provisions between 1977 and 1980 indicate that more than 80 percent of all plan participants make no contribution to coverge under the plan; more than 60 percent make no contribution for dependents' coverage.

The pooling of risks within employer group plans can generate significant cross-subsidization among employees who participate in the plan. Low-risk employees (for example, men, young employees and those with no history of chronic illness or impairment) receive benefits from the plan that may be considerably less than the employer's average cost of providing health insurance to them. Conversely, higher-risk employees (for example, women, older employees or employees with chronic health problems) receive benefits in excess of the employer's average plan costs. Because low-risk empoloyees pay little or none of the cost of the plan, however, they are indifferent to their subsidization of higher-risk participants in the health plan.

Taxation of employer contributions to health insurance raises the cost of coverage to participants in employer group health plans. Low (that is, strigent) levels of a tax cap on employer contributions create an incentive for low-risk employees to reduce their after-tax health cost by seeking less complete or less comprehensive health insurance coverage. The exit of low-risk participants from existing plans (that is, adverse selection) raises the average risk that plan-stayers represent. As a result, the average cost of the plan arises.

Employers have objected to the proposed taxation of contributions to health insurance contributions because they expect taxation to significantly raise their costs of providing health insurance benefits. Increased employer costs might result in several ways. First, employer tax liability under FICA would rise. Since employer payments to FICA are deductable under the corporation income tax, however, the net increase in employer tax liability is likely to be modest. It should be noted, however, that part of the FICA taxation of employer contributons involves shifting funds out of general revenues and into Social Security.

Second, employers anticipate that workers will respond to taxation of health insurance contributions by demanding higher cash wages or greater levels of other tax-exempt benefits in an effort to maintain pre-rax compensation levels. The adverse selection of low-risk employees from existing plans, moreover, may generate a second-round increase in employee demand or greater pre-tax compensation. As low-risk plan participants exit from the "standard" plan, the average cost of the plan -- and employer contributions for the remaining participants -- will rise. Employers are likely to be under substantial pressure from employees who benefit from generous plan coverage to continue to offer that coverage. At the same time, equivalent compensation for employees who leave generous plans would rise with increases in the average cost of the "standard" average.

Finally, because of pressure from some employees to offer less expensive alternative health insurance coverage, employers foresee increased administrative costs as well as the loss of some scale economies in their group plan benefits. The fragmenting of existing employer group plans into a number of smaller plans may increase insurance costs for smaller employers, or reduce the coverage employers are able to provide at current outlays

(iii) Impact on the rate of Health Insurance Coverage.

A potentially important problem that arises in the context of higher employer and employee costs for health insurance is the possibility that some employees would lose health insurance coverage altogether. Increases in the employer cost of providing coverage to marginal workers -- part-time or seasonal workers, and workers who are laid off -- suggests increases in the rate at which these workers and their dependents might be excluded from coverage.

To investigate the problem of coverage loss among some workers, EBRI performed a simulation of the rates of health insurance coverage that might emerge among the currently insured population in the absence of an employer contribution. EBRI's simulation of private insurance coverage rates that emerge in the absence of employer contributions provided some dramatic results. Fewer than half of all persons living in households with annual incomes less than $15,000 (in 1979) would have had private health nsurance coverage in the absence of any employer contribution (see Table 5). In addition, periods of unemployment appear to have a more significant impact on insurance coverage. It is likely that even moderate periods of unemployment (12 weeks or less) generate very long lapses in health insurance coverage among individuals and their dependents when re-employment does not provide an

TABLE 5

SIMULATION OF THE EFFECT OF INCOME ON THE PROBABILITY OF PRIVATE HEALTH INSURANCE COVERAGE, PERSONS WITHOUT EMPLOYER CONTRIBUTION TO COVERAGE BY WORKFORCE STATUS

	All Persons 1/		Workers 2/	
Family Income	Probability of Private Coverage	Change in Probability Per Income Change 3/	Probability of Private Coverage	Change in Probability Per Income Change 3/
5,000	0.3106	0.0875	0.3428	0.0785
10,000	0.3900	0.0794	0.4104	0.0712
15,000	0.4612	0.0713	0.4778	0.0638
20,000	0.5244	0.0632	0.5343	0.0564
25,000	0.5795	0.0551	0.5834	0.0491
30,000	0.6264	0.0470	0.6252	0.0410
35,000	0.6653	0.0389	0.6596	0.0344
40,000	0.6961	0.0377	0.6867	0.0271
45,000	0.7187	0.0267	0.7064	0.0197
50,000	0.7333	0.0146	0.7188	0.0124

SOURCE: EBRI analysis of private health insurance coverage.

1/ Estimates based on persons under age 65 living in households of civilian wage and salary workers.
2/ Estimates based on civilian wage and salary workers.
3/ Income unit is five thousand dollars.

employer contribution to health insurance.

The importance of demographic variables in explaining health insurance coverage, controlling for the effects of income and unemployment, is of particular interest. Persons living in households with no spouse present are significantly less likely to have health insurance coverage in the absence of an employer contribution than are persons living in households with a spouse present. This remains true, even when children are present in the household. Younger families (persons living in a household with a younger primary earner) are also much less likely to have health insurance coverage. The significance of demographic variables in determining private health insurance coverage implies that the current system of employer contributions has significantly raised "normal" rates of health insurance coverage throughout the population, despite perverse demographic trends.

Thse simulations cannot provide precise estimates of the changes in health insurance coverage among the population that might ensue if employer contributions to health insurance were taxed either in whole or in part. They do indicate, however, the function served by current tax preferences for employer health insurance contributions. Current tax policy probably raises private coverage rates significantly among lower-income worker households, households with fragmented employment histories, younger households, and both single-person and single-parent households.

(iv) Impact on Tax revenue and burden

Estimates of the tax revenues that might result from the taxation of employer contributions to health insurance have attracted considerable attention from those seeking new sources of federal revenues. These estimates have invariably been high and, based on assumptions of contiued growth in employer health insurance costs, rise significantly over the next few years. The Congressional Budget Office (CBO) estimate of new federal revenues that might result from a low (that is, stringent) cap -- $1440 annually for family coverage and $576 for individual coverage -- effective in 1983, is $4.6 billion. Based on static coverage assumptions, CBO's projected estimates of potential federal revenues between 1983 and 1987 reflect an average annual growth rate of more than 30 percent. In spite of their size, however, estimates of federal revenues that might result from taxation of employer health insurance contributions are fragile. They are susceptible to their assumptions about post-tax levels of employer contributions, as well as to the particular level of taxation proposed.

The primary assumptions behind projected federal revenues from the taxation of employer contributions include: (1) the cost of health insurance coverage, (2) the rate of employer contributions as a percent of cost, and (3) the rate and distribution of health insurance coverage among worker households. The usual cost factor used for projecting health insurance premiums is the medical care component of the Consumer Price Index. Generally, both the rate of employer contributions, and the rate and distribution of health insurance coverage, are assumed to remain at their present levels after a tax cap is imposed.

Although use of these assumptions probably introduces substantial error into the calculation of potential revenues, virtually any other assumptions would be equally hypothetical. The cost of private health insurance relies, for example, on the package of health benefits offered by employers, reimbursement arrangements made with providers and the shortfall of Medicaid and Medicare reimbursements relative to provider costs. All of these factors are in the midst of dramatic change. Researchers have not developed a method, however, for accurately predicting the effects of these changes on employers' insurance costs. Nevertheless, it is clear that they will affect the ultimate yield of a tax on health insurance contributions. While the use of the CPI to adjust health insurance costs may understate the near-term cost trend of private health insurance, assuming (1) constant rates of employer contribution and (2) constant coverage rates across worker households, however, probably biases tax revenue estimates upwards. Ironically, both advocates and critics of revised tax policy cite the reductions in the comprehensiveness of coverage and redistribution of the scope and rate of insurance coveage as likely effects of reduced tax preference. These effects are not reflected, however, in federal revenue projections.

Possibly of more interest than the level of potential revenues from a cap on the exclusion of employer contributions is the sensitivity of revenue estimates to different levels of the cap. CBO's projections of potential revenues indicate that a relatively small increase in the level of contributions excluded from federal income and payroll taxes would produce a significant drop in projected revenues. Raising the cap from $1980/$792 (family coverage/individual coverage) to $2160/$864 (a 9 percent increase in the level of contributions excluded from earnings), reduces the estimated revenues that might result by 22 percent (see Table 6).

The sensitivity of these revenue estimates to modest adjustments in the level of the proposed cap reflects the relatively narrow dollar range of employer contributions to health insurance, and the weak relationship between the size of employer health insurance contributions and household income.

TABLE 6

SENSITIVITY OF PROJECTED FEDERAL REVENUES TO SELECTED TAX EXCLUSION LIMITS, 1983

Proposed Limit Family/Individual Coverage (annual)	Projected Federal Revenue 1/ (in billions)	Increase in Limit (per cent)	Decrease in Projected Revenue (percent)
$1440/576	$ 4.6	-	-
1620/648	3.7	12.5	19.6
1800/720	2.9	11.1	21.6
1980/792	2.3	10.0	20.7
2160/864	1.8	9.1	21.7

SOURCE: Congress of the United States, "Congressional Budget Office, Containing Medical Care Costs Through Market Forces," (May 1982), p. 35.

1/ Includes revenues from both individual income and Social Security taxation of simulated employer contributions above the exclusion limit in 1983. Social Security tax revenues represent about one quarter of total projected tax revenues.

Among all employer group health plan participants included in the National Medical Care Expenditures Survey, 75 percent of those with an employer contribution to individual coverage received a contribution amount between $100 and $500 in 1977. The range of employer contributions to family coverage was comparably narrow. More than half of all plan participants with an employer contribution to family coverage received a contribution amount between $500 and $1200 in 1977. 11/ Because of the relatively narrow range of these contributions, modest adjustments to the level of proposed cap can affect a significant proportion of all persons who receive an employer contribution to coverage.

Employer contributions to health insurance are broadly distributed across households at most levels of income. In 1979, the rate of coverage among persons with family income above $15,000 was high (73 percent or more) and varied little by income (see Table 7). More than 90 percent of all persons with employer group coverage, including persons in the very lowest ranges of income, received an employer contribution to coverage. As a rsult, the distribution of employer contributions to health insurance coverage is very similar to the distribution of employer group coverage across the population, with little variation in the dollar amount received by households at different levels of income.

The distribution of tax burden that would result from limiting the tax exclusion of employer contributions to health insurance reflects the flat distribution of employer contributions to health insurance over most levels

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10/ G. R. Wilensky and A. K. Taylor, "Tax Expenditures and Health Insurance: Limiting Employer-Paid Premiums," Public Health Reports (July-August, 1982).

TABLE 7

RATES OF EMPLOYER GROUP COVERAGE AND EMPLOYER CONTRIBUTIONS TO GROUP COVERAGE BY TOTAL FAMILY INCOME 1/, 1979

Total Family Income	Proportion of Persons With Employer Group Coverage	Proportion of Covered Persons With Employer Contribution	Proportion of All Persons With Employer Contributions
Loss	16.7	85.0	14.2
$ 1- 4,999	9.3	88.2	8.2
5,000- 7,499	22.7	86.3	19.6
7,500- 9,999	33.3	89.5	29.8
10,000-14,999	53.1	91.5	48.6
15,000-19,999	72.4	92.5	67.0
20,000-24,999	78.8	94.0	74.1
25,000-29,999	81.9	94.7	77.6
30,000-34,999	83.6	94.4	78.9
35,000-39,999	82.0	94.5	77.5
40,000-49,999	82.0	93.9	77.0
50,000-59,999	81.8	92.1	75.3
60,000-74,999	77.4	91.9	71.1
75,000 +	73.6	87.0	64.0
Total, all persons 2/	60.6	92.9	56.3

SOURCE: EBRI tabulations of the March 1980 Current Population Survey (Bureau of the Census, U.S. Department of Commerce).

1/ Includes earnings, property and transfer income.
2/ Includes some persons reporting no income in 1979.

of family income. Employer contributions that are relatively constant at all income levels represent a larger percentage addition to family income at lower levels of income than at higher levels of income. As a result, limiting the exclusion of employer contributions to health insurance tends to place a relatively heavy tax burden on families at lower levels of income. In general, the federal income tax structure is not sufficiently progressive to offset both the distribution of employer contributions and the regressivity of the Social Security tax on earnings.

CBO's estimates of the tax burden that would result from capping the exclusion of employer contributions to health insurance are presented in Table 8. These estimates indicate that the distribution of tax burden across households at all income levels would be only mildly progressive, and regressive at income levels above $30,000. The mild degree of progressivity over very low levels of income is due primarily to lower rates of employer group coverage among low-income persons with relatively fragmented workforce participation patterns.

Among households that would be affected by a cap of the exclusion of employer contributions to health insurance, the tax burden would be severely regressive. As a proportion of income, persons at the lowest levels of income (those reporting less than $10,000), would pay more than six times the amount of additional tax than would persons with income over $50,000. The regressive impact of taxing employer contributions to health insurance is a major argument against porposals to limit the exclusion of contributions at all but the very highest level. The argument for pursuing a high exclusion limit, however, is weak; a high cap would affect only a small proportion of all households and yield very little additional federal revenues.

TABLE 8

DISTRIBUTION OF ADDITIONAL ANNUAL TAX BURDEN OF $1800 ANNUAL EXCLUSION LIMIT IN CALENDAR YEAR 1983, BY HOUSEHOLD INCOME

(in dollars) 1/

	All Households		Households Affected		
Annual Household Income 2/	Average Additional Taxes	Percent of Income	Percent Affected by Limit	Average Additional Taxes	Percent of Income 3/
$ 0-10,000	3	0.05	2	138	2.76
10,001-15,000	14	0.11	9	168	1.34
15,001-20,000	21	0.12	14	147	0.84
20,001-30,000	44	0.18	23	191	0.76
30,001-50,000	88	0.22	33	267	0.68
50,001-100,000	116	0.18	36	323	0.43
Over 100,000	108	0.08	27	403	0.40

SOURCE: Congress of the United States, Congressional Budget Office, "Containing Medical Care Costs Through Market Forces" (May 1982), p. 36.

1/ Includes both federal income tax and the employer's and employee's share of Federal payroll taxes. About three-quarters of the tax burden results from federal income tax liability. State and local income taxes are excluded. Estimates assume that taxable excess contributions are ineligible for the medical expense deduction under the federal income tax.

2/ Household income before taxes, but including cash transfer payments (e.g., Social Security benefits, projected to calendar year 1983.

3/ Estimated at the midpoint of the income range.

The Effectiveness of Tax policy in Containing Health Care Costs

Although industry surveys indicate that employers have been raising deductibles and copayments in their group plan coverage, these plans have traditionally been generous. Coverage of hospital care, in particular, has traditionally involved little cost-sharing on the part of insured consumer. This pattern of generous coverage for hospital care emerged for many reasons; possibly the most imporant is simply the historical precedent established by hospital and physican-owned Blue-Cross/Blue Shield plans in the 1930s. Federal tax policy has not discouraged the emergence of generous health insurance plans. At the same time, empirical studies suggest that tx policy has been only a minor contributor to the development and growth of these plans.

Private insurance that requires little or no cost-sharing by consumers of health care has probably raised the demand for health care services and contributed to inflation in health care costs. The relative importance of private insurance as a source of demand and inflationary pressure in the health services market, however, has been declining.

Hospital care is the most inflationary component of health care services. Since 1965, the proportion of all hospital care purchased with private insurance has fallen steadily. Since 1975, moreover, private consumers have paid an increasing share of most health care services, including hospital care, directly out of pocket. Between 1975 and 1981, the real burden of hospital care borne directly by private consumers rose by almost one third (see TAble 9).

The most important source of expanding coverage and rising health service demand over the last two decades has been the public sector. Since

TABLE 9

PERCENTAGE DISTRIBUTION OF EXPENDITURES FOR HOSPITAL CARE BY SOURCE OF PAYMENT, SELECTED YEARS 1965-1981

	Private				Public		
	Total	Patient Direct Payments	Health Insurance	Other	Total	Medicare and Medicaid	Other
1965	61.2	17.2	41.8	2.2	38.9	--	38.9
1970	47.2	10.0	35.8	1.4	52.9	26.3	26.6
1975	44.7	8.2	35.4	1.1	55.3	31.3	24.0
1978	45.6	8.6	35.8	1.2	54.4	33.6	20.9
1979	46.2	9.9	35.0	1.3	53.8	33.9	19.9
1980	45.9	10.0	33.5	1.5	54.1	35.3	18.8
1981	45.7	10.8	33.4	1.5	54.3	35.7	18.6

SOURCE: R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1981," Health Care Financing Review 4:1 (September 1982), pp. 24 and 27. R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review, 3:1 (September 1981), pp. 44-47.

1967, the public sector has purchased more than a third of all personal health care, and more than half of all hospital care. Most of the growth of public-sector spending for personal health care is attributable to the growth of Medicare and Medicaid spending. In 1981, these programs purchased more than one third of all hospital care delivered in the United States.

The size of public-sector spending relative to privately-insured spending for personal health care is important in considering a revision of federal tax policy toward private health insurance, both at a philosophical and a practical level. In legislating the Medicare and Medicaid programs, Congress established a standard of access to comprehensive health insurance coverage across the population. Federal tax policy that would significantly reduce levels of private health insurance coverage, or jeopardize access to coverage among middle-and low-income persons, promotes gross inequities between the general population and persons eligible for coverage through the public sector. Federal policy that would reduce eligibility or coverage under Medicare or Medicaid, moreover, is reasonable only if persons who lose public-program benefits are likely to obtain health insurance coverage in the private sector. It is difficult to reconcile reductions in both public-program benefits and private-sector incentives for health insurance coverage in terms of coordinated federal policy.

In practical terms, the size of public spending for personal health care relative to privately insured spending suggests that federal policy to contain health care cost inflation might be most effective within the context of federal spending programs. In spite of efforts to curb the burgeoning costs of Medicare and Medicaid, these programs have supported much of the inflation of aggregate health care costs, and of hospital costs in particular. The average Medicare beneficiary spends far more for hospital care than privately insured persons. Over the last five years for which data are available, per capita spending for hospital care among Medicare enrolles exceeded per capita spending among the privately insured population by more than 400 percent (see Table 10). While part of the discrepancy in per capita spending for hospital care is the result of differences in the insured population, at least some of the difference is attributable to hospital practices that are attuned to Medicare and Medicaid reimbursement policy.

Possibly due to the success of health care providers in gaming Medicare and Medicaid reimbursement, these public programs have led inflation in hospital costs. Beween 1976 and 1980, the rate of increase in average Medicare and Medicaid spending consistently exceeded the growth of privately insured spending for hospital care. During those years, average hospital costs among Medicare enrolles and Medicaid beneficiaries rose at an average annual rate of 14 and 18 percent, respectively. Average private health insurance costs, by comparison, rose by less than 12 percent, and maintained a stable decline during 1979 and 1980. It is unlikely that these persistent differences in per capita spending between public-sector programs and privately insured consumers are the result of qualitative changes in the covered populations.

Federal tax policy that would dampen private-sector demand for health care will probably have little effect on health care cost inflation as long as Medicare and Medicaid spending continues to rise. Inflation in privately insured spending for hospital care and other health care service has been slowing, possibly in response to adjustments in the coverage provided by employer group plans. Modifying the tax-exempt status of

TABLE 10

ESTIMATED AMOUNT AND ANNUAL GROWTH OF EXPENDITURES FOR HOSPITAL CARE PER INSURED PERSON BY SELECTED SOURCE OF PAYMENT, 1976-1980

	Private Health Insurance 1/	Medicare 2/	Medicaid 3/
	(dollars per insured person)		
1976	$122	$486	NA 4/
1977	134	540	NA
1978	149	687	$315
1979	164	772	442
1980	181	926	495
Average, 1976-1980	150	682	417
	(percent annual growth)		
1976	18.4	3.2	NA
1977	9.8	11.1	NA
1978	11.2	27.2	13.6 5/
1979	10.1	12.4	40.3
1980	10.4	19.9	12.0
Average annual growth, 1976-1980	11.9	14.5	18.3

SOURCE: R.A. Gibson and D.R. Waldo, "National Health Expenditures, 1981," Health Care Financing Review, 4:1 (September 1982), pp. 24, 27. R.A. Gibson and D.R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review 3:1 (September 1981), pp. 44-46. Health Insurance Association of America, Source Book of Health Insurance Data, 1981-1982 (Washington, D.C.), p. 12. U.S. Department of Health and Human Services, Social Security Administration, Social Security Bulletin Annual Statistical Supplemental, 1981 (Washington, D.C.), pp. 207,220.

1/ Private insurance expenditures per person insured for hospital care.
2/ Medicare expenditures per Medicare Part A enrollee.
3/ Medicaid expenditures per Medicaid recipient (unduplicated count) of any personal health care services, including hospital care.
4/ Published figures not available.
5/ Average annual compounded growth between 1975 and 1978.

employer contributions to health insurance may accelerate this trend. It is very unlikely, however, that further slowing of privately insured spending for health care can successfully offset continued inflation in public-sector spending.

Concluding Remarks

Employers and employees, public and private, have placed a consistently high value on employee benefits. Many benefits, such as holidays and other time off, are fully taxed. The government has encouraged the growth of other benefits through tax incentives. Past concern over low rates of private health insurance and pension coverage among workers, even with tax incentives, has led to discussions of national health insurance and mandatory private pensions. Now, concern over deficits is leading to proposals that could have the effect of reducing coverage in these tax-favored programs.

Without question, the federal government must draw lines to specify which employee benefits should be tax-favored. Great care, however, must be taken to avoid unintended consequences. Consideration of tax policy change must include a clear definition of objectives, the assessment of individual benefits against these objectives, and, finally, a thorough understanding of the tax costs of each benefit. This process can only be effective if analysts understand the distinction between mandated versus voluntary benefits; fully taxed versus tax favored benefits, and tax-exempt versus tax-deferred benefits. Most analyses and debate in recent years have not made these distinctions.

We thank you for the opportunity to appear today. We stand ready to assist the Congress in its debate with further analysis of the tax treatment of employee benefits and related issues.

Senator **Durenberger**. Let me express my appreciation to all of you. In each case there is a fair amount of backup material. Let me assure that those of us who are interested in the various subjects that are before us today in terms of how we can do better or more in the general area of the employer-employee relationship are going to lean very heavily on all of you who have some expertise in that field.

I would just, on a personal basis, refute the latter part of your testimony, Mr. Salisbury, relative to motivation. I personally do not come to the issue of the tax cap in terms of raising revenue. If I did that, I'd be a flat-rate taxer, and I'd just come in and wipe out the whole works including the business deduction.

So just so there is no misunderstanding of where my heart is on the issue, it's in the area of: How do we get more flexibility into the system? How do we preserve the value of that special relationship that employers and employees have built up between themselves?

And to help all of you who are in this business, I guess, I would bring choice into the health care system by bringing choice into that relationship. That's why we pushed on Buck this morning about getting the regulations out, and he pushed back on us about making up our minds—are we going to sit here every year and have moratoria forever on fringe benefit compensation, or are we ever going to address this issue and try to reach a consensus?

So if you can help push us, either in your expert capacity or through your clients, to come to grips with this whole issue of that relationship and the value of that relationship, keeping in mind the fear that seems to be there in Treasury and some other places that folks who espouse cafeteria plans and who espouse the use of the Tax Code in that benefit relationship are just trying to push us into a British kind of system where we forget about cash and we only deal in benefits—and remember there are some people that think that way and think that's really what we are up to. I for one am not. I presume you wouldn't have gone to the work of putting all these statistics together if it weren't to demonstrate that isn't the objective in this.

Mr. **Salisbury**. I was only suggesting, Senator, that given the revenue estimates, they should not be the motivation. Analysis of the health tax cap should be based upon the other issues that you articulated. But on the revenue side, in line with Senator Dole's statements earlier, there shouldn't be great reliance placed on the fact that, quote, "the tax cap by definition will raise large amounts of money," unquote.

Senator **Durenberger**. Right.

Thank you very much.

Thank you all for your testimony. Your full statements will be made part of the record.

Our first witness this afternoon is Mr. Bernard Aidinoff, the chairman, section of taxation, American Bar Association. He will be followed by a panel of: Dr. James Strain; John F. Troy, Jr.; Bernie Tresnowski; and Burt Press of the American Dental Association—just so all four of you know you are up next.

Thank you very much, Bernie, for being here. We look forward to your testimony. Your full statement will be made part of the record.

STATEMENT OF M. BERNARD AIDINOFF, CHAIRMAN, SECTION OF TAXATION, AMERICAN BAR ASSOCIATION, WASHINGTON, D.C.

Mr. AIDINOFF. Mr. Chairman, my name is M. Bernard Aidinoff, of New York City. I am chairman of the section of taxation of the American Bar Association. I am accompanied by Mr. Tom Marinis. I appear before you today to present the views of the American Bar Association on the taxation of nonstatutory fringe benefits.

The American Bar Association recommends that Congress adopt definitive and comprehensive legislation for the taxation of fringe benefits and that this legislation be adopted without a further extension of the freeze scheduled to expire on December 31.

The taxation of fringe benefits has been a continual source of confusion and difficulty in our Federal income tax system. There has been an uneven administration of the tax law which has contributed to an overall perception of unfairness and a lack of confidence in the system.

Extension of the freeze beyond December 31 will continue this confusion and uncertainty.

The American Bar Association recommends the adoption of a legislative solution to the fringe benefit problem which preserves the existing treatment of such fringe benefits but which also satisfies the important tax policy objectives of simplicity, ease of administration, and fairness, and does not provide for growing erosion of the tax base.

Since 1975 various professional groups have made various proposals on the taxation of nonstatutory fringe benefits. The proposal of the American Bar Association establishes a general rule that a fringe benefit should be included in gross income unless it is covered by one of four exclusionary rules. The three principal exclusions are as follows:

A fringe benefit would be excludable from gross income if it is incident to the employer's trade or business, it is provided on a nondiscriminatory basis, and the marginal or incremental cost of providing the benefit is insubstantial.

Our second exclusion is that a fringe benefit would be excluded from gross income if it is provided primarily for the benefit of the employer rather than the employee.

Third, insubstantial benefits would not be included in gross income if they are not provided on a frequently recurring basis.

I will now discuss the three principal exclusionary rules in more detail.

The first exclusionary rule would be for nondiscriminatory benefits that are incident to the employer's trade or business and are available without any substantial marginal or incremental cost to the employer. These are often referred to as "mass benefits."

Examples of fringe benefits that often qualify for exclusion under this rule would be airline or railroad transportation passes, tuition remission programs, and retail store discounts. In each case the benefit can be made available to the employee at no significant marginal cost to the employer, and the goods, service, or facility is an inherent part of the employer's business.

These benefits would qualify for exclusion under the ABA proposal as long as they are provided on a nondiscriminatory basis. The abuse potential of this exclusion would be limited by the requirement that the benefits be made available on a nondiscriminatory basis. If they were made available only to senior officers, shareholders, et cetera, it would not so qualify.

The proposal defines the marginal costs of a fringe benefit as a "cost incurred by the employer that would not have been incurred but for the fact that the benefit was provided." Obviously, marginal costs would have to be defined by regulation.

Similarly, benefits that are provided primarily for the benefit of the employer would not be taxable. Examples of benefits that would fall within this general area are bodyguards and transportation provided to and from job sites through dangerous areas, employment agency fees, supper money provided for employees who occasionally work abnormal hours.

We would also exclude from gross income items of nominal value.

When fringe benefits are includable in income, we would have them includable at fair market value, not at cost and not at marginal cost.

We have attached to our statement various examples illustrating these proposals as well as proposed statutory language. The ABA Section of Taxation stands ready to give your staff any help that it might need or desire. We think that it is crucially important that we finally reach solutions on this problem and that we not extend the freeze beyond this December 31.

I would be happy to answer any questions that you may have.

[The prepared statement of M. Bernard Aidinoff follows:]

STATEMENT OF M. BERNARD AIDINOFF, CHAIRMAN SECTION OF TAXATION ON BEHALF OF THE AMERICAN BAR ASSOCIATION

My name is M. Bernard Aidinoff of New York City. I am Chairman of the Section of Taxation of the American Bar Association. I appear before you today to present the views of the American Bar Association on the taxation of non-statutory fringe benefits.

The American Bar Association recommends that Congress adopt definitive and comprehensive legislation for the taxation of fringe benefits and that this legislation be adopted without a further extension of the "freeze" scheduled to expire on December 31 of this year.

The taxation of in-kind economic benefits or "fringe benefits" received in connection with the performance of services has been a continual source of confusion and difficulty for our federal income tax system. Although section 61 of the Internal Revenue Code defines "gross income" as all income from whatever source derived, in practice many fringe benefits have not been taxed. In many instances, these benefits have escaped taxation simply as a result of uneven administration of the tax law and through reliance on the audit lottery. In other instances, benefits have been excluded based on an Internal Revenue Service administrative interpretation that the particular benefit was not taxable. This authority has generally constituted an *ad hoc* exercise of administrative discretion rather than the application of consistent underlying logical principles.

The absence of a clear statement of the principles that distinguish taxable and nontaxable fringe benefits fosters inconsistent administration of the statute. Too much has been requested of the discretion of Internal Revenue Service field personnel during the audit process. In some cases, the taxation of fringe benefits has received great emphasis in the audit process, while in others the treatment of fringe benefits has not been raised. In cases where fringe benefits have been raised, it has not been unusual for the same benefit to be treated differently from one audit jurisdiction to another. The resulting uncertainty has forced taxpayers to resort to speculative determinations in planning and reporting benefits arising out of the performance of services. Further, similarly situated taxpayers are being treated differently depending on whether or not the existing rules, such as they are, are being followed. While it is difficult to quantify the magnitude of the problem, there can be little doubt that the general state of confusion and uncertainty has contributed to an overall perception of unfairness and lack of confidence in our federal tax system. The negative impact on taxpayer confidence is far more significant than any revenue loss or gain associated with taxing or not taxing fringe benefits.

Extension of the moratorium on fringe benefit regulations beyond December 31, 1983, will result in a continuation of this confusion and uncertainty to the detriment of the federal tax system.

The Treasury Department recognized the desirability of a comprehensive and uniform set of rules for the taxation of non-statutory fringe benefits as early as 1975, when it published a "discussion draft" of proposed regulations. While stated in terms of general principles, the effect of the discussion draft would have been to codify the existing treatment of most fringe benefits. After generating substantial controversy, the draft was withdrawn in December, 1976. A subsequent announcement of intention to propose regulations by the Commissioner of Internal Revenue in March of 1977 led to a Congressional freeze on new fringe benefit regulations. That freeze has been extended from time to time, but it is currently set to expire on December 31, 1983.

Since 1975, several professional groups have recommended comprehensive solutions to the fringe benefit problem, either by legislation or regulations. The ABA proposel, calling for adoption of legislation, was approved in August, 1980. A copy together with the explanatory report is attached to this statement. Further, the ABA Tax Section is available to provide assistance and technical advice on statutory language.

A basic policy question is whether the fringe benefits problem should be solved by legislation, regulation, or by audit and court decision. The American Bar Association recommends a legislative solution for two reasons. First, as a matter of principle, a tax policy issue of such large dimensions and involving so many taxpayers should be resolved through the legislative process. Only Congress can make the difficult tax policy judgments. The experience of the past eight years is itself an argument that the regulatory, audit, and court processes cannot deal with the problem most equitably and efficiently. Second, the uncertainties and confusion that presently exist are in part a result of the conflict between the broad language of section 61 of the Code and various administrative regulations and rulings authorizing the exclusion of certain fringe benefits. That fundamental conflict will not be eliminated by regulations or audit solutions. A course of litigation is not efficient.

The fringe benefit issue involves complex questions of tax policy, which are particularly difficult in their present historical context. Issues that at one time could have been dealt with easily are complicated by long-standing administrative interpretation or unchallenged and widely held perceptions that a particular benefit is not taxable. The Association's recommendation addresses this historical problem by fashioning a series of rules that, to the extent possible in a comprehensive proposal, preserves the status quo regarding taxation of fringe benefits and is fair, simple, easy to administer, and does not erode the present tax base. Safeguards against abuse have been provided.

The ABA proposal establishes a general rule that a fringe benefit is to be included in gross income unless it is covered by one of four exclusionary rules. First, a fringe benefit would be excludable from gross income if (a) it is incident to the employer's trade or business,

(b) it is provided on a nondiscriminatory basis, and (c) the marginal or incremental cost of providing the benefit is insubstantial. Second, a fringe benefit would be excludable from gross income if it is provided primarily for the benefit of the employer rather than the employee. Third, insubstantial fringe benefits would not be includable in gross income if they are not provided on a frequently recurring basis. And finally, there is a technical rule that clarifies that the value of certain employer-furnished recreational facilities are excluded from gross income when the costs of furnishing such facilities qualify for deduction under existing rules. If a fringe benefit does not meet one of the four standards for exclusion, the amount includable in gross income would be equal to the excess of the fair market value of the benefit over the amount paid for the benefit by the recipient.

I will now discuss the three principal exclusionary rules in more detail.

Exclusion for Mass Benefits Incident to a Trade or Business

The first exclusion would be for nondiscriminatory benefits that are incident to the employer's trade or business and are available without any substantial marginal or incremental cost to the employer. These are often referred to as "mass-benefits". Examples of fringe benefits that would often qualify for exclusion under this rule are airline or railroad transportation passes, tuition remission programs, and retail store discounts. In each case the benefit can be made available to the employee at no significant marginal cost to the employer and the good, service, or facility is an inherent part of the employer's business. These benefits would qualify for exclusion under the ABA's proposal as long as they are provided in a nondiscriminatory manner.

It is inappropriate to impose a tax based on prevailing market values on an employee who simply avails himself of goods or services that are available because of the nature of the employer's business. In many such cases the decision to use or forego such a benefit is casual and sporadic. The subjective value of the fringe benefit to the employee may be substantially less than its objective market value. The principal effect of imposing a tax on the basis of the fair market value of such a benefit is to discourage employees from using the benefit. This contrasts with a benefit that is not incident to the employer's business, and which is much more likely to be viewed as compensation both by the employer and the employee. In these circumstances, the subjective value of the benefit to the employee probably comes close to its objective market value.

The abuse potential of this exclusion would be limited by requirements that the benefit be made available on a nondiscriminatory basis and that the marginal cost incurred by the employer in providing all such benefits may not be substantial in relation to the total cash compensation paid to all employees eligible to receive the benefits.

A service or product provided by an employer would be considered incident to the business of the employer if it is provided primarily to persons dealing with the employer in the ordinary course of its business, or if it is available because it is otherwise necessary or appropriate to the accomplishment of the employer's business objectives. Use of a facility made available by an employer would be considered incident to the employer's business if the facility is owned or controlled by the employer for purposes necessary or appropriate to the conduct of its trade or business, as opposed to primarily for the personal benefit of employees.

The proposal defines the marginal cost of a fringe benefit as the cost incurred by the employer that would not have been incurred but for the fact that the benefit was provided. The marginal cost of a fringe benefit would not include any loss of revenue actually or potentially suffered by the employer as a result of providing the benefit. Moreover, it would be determined without reference to any of the employer's fixed costs, except fixed costs that are included in the cost of inventory following the method of accounting used by the employer for tax purposes. The proposal contemplates that the Service would issue regulations on the computation of marginal costs.

Even though a benefit is incident to the employer's trade or business, it would not be excluded from gross income by the ABA recommendation unless it is made available to a reasonable classification of individuals established by the employer. The establishment of reasonable classifications would be permitted in recognition of the fact that it may be inappropriate to make certain benefits available to all individuals. Whether a classification is reasonable would be judged by reference to all the facts and circumstances. Factors such as age, length of service, and job classification should be taken into consideration. A classification would be unreasonable if its effect would be to discriminate in favor of officers, shareholders or other owners, or highly compensated individuals.

Exclusion for Benefits Provided for the Benefit of the Employer

The policy basis for excluding items provided primarily for the benefit of the employer, as opposed to the employee, is that such items are generally not compensatory in nature. The fact that an employee might derive some incidental personal benefit or enjoyment from a benefit should not result in its value being included in his gross income.

Whether a fringe benefit is provided primarily for the benefit of the employer is a question of fact, requiring an analysis of the circumstances under which the benefit is provided, including whether the benefit is available to a broad cross-section of employees, whether it is basically a condition of employment, and whether it is intended primarily to further the employer's business objectives, other than paying compensation.

Examples of benefits that would fall within the general scope of this exclusion are bodyguards and transportation provided to and from job sites through dangerous areas, employment agency fees paid by an employer and supper money provided for employees who occasionally work abnormal hours.

Exclusion for Benefits of Nominal Value

Benefits of nominal value should be excluded from gross income because the cost of accounting for such benefits and enforcing a policy of inclusion is not justified by the small amount of additional tax revenue involved. A benefit should be considered of nominal value, and thus nontaxable, if its fair market value is not more than $50 or the value is unknown, but is so small that accounting for it is unreasonable or administratively impractical. To prevent abuse, the recommendation also provides that a benefit cannot be provided on a frequently recurring basis and remain exempt under this *de minimis* rule. Some thought was given to imposing an aggregate annual limitation of $500 for *de minimis* benefits, but the idea was rejected because it would defeat the purpose of the *de minimis* exclusion by making it necessary to account for all benefits of nominal value to determine whether the aggregate limitation had been exceeded.

Valuation of Includable Fringe Benefits

Under the ABA's recommendation, a fringe benefit that does not fall within one of the categories of excludable benefits would be includable in gross income. The amount to be included in gross income would be the excess of the fair market value of the benefit over the amount, if any, paid for the benefit.

The proper measure of value of an otherwise includable benefit is perhaps the most difficult policy determination that must be made in fashioning an approach to the taxation of in-kind benefits. Other professional groups have proposed that the valuation of fringe benefits for federal income tax purposes be based on cost, or even marginal cost, principally on grounds of simplicity and ease of administration. Simplicity and ease of administration are important policy goals, but we believe that the proponents of cost valuation overstate the complexities of market valuation compared to cost. To some degree, both measures are arbitrary and clearly both have their complexities. However, the use of a fair market value standard has the virtue of being consistent with the method traditionally applied for most other purposes under the Internal Revenue Code. To the extent that the fringe benefits are taxed as comparable to the receipt of cash, valuation based on objective fair market value is the most fair. Balancing the objectives of easy administration, consistency with other Code provisions, and fairness among taxpayers, the ABA recommends that taxable fringe benefits be valued at fair market value when determining whether the benefit is excludable under the de minimis rule and when determining the amount includable in gross income.

The ABA's proposal applies to any fringe benefit provided in connection with the performance of services, not merely to benefits provided by an employer for its common-law employees. Thus, benefits received by an independent contractor would be taxable in accordance with the principles of our recommendation, as would any benefits received by the family or friends of the individual who performed services for the person who provided the fringe benefit. Such treatment is consistent with the principles of section 83 of the Code. The proposal would also apply to fringe benefits received by a partner from his partnership.

The recommendation is not intended to have any effect upon the tax treatment of fringe benefits specifically dealt with by other provisions of the Code, including qualified plans, group term life insurance, health and accident plans, and legal service plans. In addition, any benefit that constitutes a transfer of property, which is not excludable under our proposal, would remain subject to section 83 of the Code.

The ABA proposal relates only to the amount of income which must be recognized by recipients of fringe benefits. Deductions available to the providers of benefits would continue to be governed by existing provisions of the Code and regulations.

The recommendation does not specify the tax treatment of particular fringe benefits. Although specific treatment of particular benefits might result in somewhat greater certainty with respect to those particular benefits, it is not possible to anticipate all the items that might now or at some time in the future be provided as fringe benefits. Moreover, particular fringe benefits might properly be taxable under some circumstances, but not under other circumstances. Accordingly, the ABA proposal is limited tc a statement of general principles under which the tax consequences of the receipt of a fringe benefit are to be determined. It is a viable way to distinguish between taxable and non-taxable fringe benefits that is fair, simple, easy to administer, does not erode the present tax base, and remains generally consistent with long-established practices.

ABA's general approach is similar to the discussion draft prepared by the House Ways and Means Committee Task Force on Fringe Benefits early in 1979. The main difference is that the Task Force draft includes an overall $1,000 aggregate limitation on excludable benefits. Benefits for the convenience of the employer and de minimis benefits would not count toward this limitation.

Mr. Chairman, I appreciate the opportunity to participate in these hearings, and once again offer the technical expertise of the ABA Section of Taxation to assist you in any way possible.

TO AMEND THE INTERNAL REVENUE CODE OF 1954 TO SET FORTH RULES FOR THE TAXATION OF FRINGE BENEFITS.

RESOLUTIONS

RESOLVED that the American Bar Association recommends to the Congress that the Internal Revenue Code of 1954 be amended to provide (1) that the value of a fringe benefit shall be excluded from gross income if (a) the benefit is incident to the employer's business and is provided on a nondiscriminatory basis at no substantial marginal cost, (b) it is provided primarily for the benefit of the employer, (c) the expense of supplying the benefit is excepted from the requirements of section 274(a) by section 274(e)(5), or (d) it is not provided on a frequently recurring basis and its fair market value is either not more than fifty dollars or is so small as to make accounting for it unreasonable or administratively impractical; and (2) that the excess of the fair market value of a taxable fringe benefit over the amount paid therefor shall be included in the gross income of the individual who performed the services on account of which the benefit was made available:

FURTHER RESOLVED that the Section of Taxation is directed to urge on the proper committees of the Congress amendments which will achieve the foregoing results.

Summary

Although section 61 broadly defines gross income as all income from whatever source derived, certain kinds of benefits arising out of the employment relationship traditionally have not been reported as gross income. Various Code provisions, regulations, rulings, and court decisions provide authority for the omission of some of these benefits from gross income. Many benefits, however, are not the subject of any specific authority, and this lack of authority has resulted in inconsistent treatment of similar items by the Internal Revenue Service.

It is recommended (1) that taxpayers be permitted to exclude from gross income the value of a fringe benefit if (a) the benefit is incident to the employer's business and is provided on a nondiscriminatory basis at no substantial marginal cost, (b) it is provided primarily for the benefit of the employer rather than the employee, (c) the expense of supplying the benefit is excepted from the requirements of section 274(a) by section 274(e)(5), or (d) it is provided only infrequently and its fair market value is either not more than fifty dollars or is so small as to make accounting for it unreasonable or impractical; and (2) that the amount includible in gross income with respect to a taxable fringe benefit be determined by reference to the fair market value of such benefit.

Discussion

Section 61 broadly defines gross income as "all income from whatever source derived, including . . . [c]ompensation for services, including fees, commissions, and similar items." Moreover, Reg. § 1.61-2(d)(1) provides that property or services received as compensation must be included in income at fair market value. This language has been cited by the Service and the courts in determining that various employee fringe benefits constitute income to the recipient. *See, e.g., Silverman v. Commissioner,* 253 F.2d 849 (8th Cir. 1958) (wife's expenses on foreign trip); *Vierling, Jr. v. Commissioner,* T.C. Memo 1969-116 (automobile); *Bell Electric Co. v. Commissioner,* 45 T.C. 158 (1965), *acq.* 1966-2 C.B. 4 (trips abroad for sales performance).

Congress has by statute excluded from gross income certain economic benefits received by employees as a result of the employment relationship. Examples of such nontaxable benefits include group term life insurance coverage, employer provided health insurance, meals and lodging furnished for the convenience of the employer, and group legal services plans. Sections 79, 105, 119, and 120.

In addition, and notwithstanding the broad language of section 61 and the regulations thereunder, other items of economic benefit received by employees as a result of the employment relationship traditionally have not been classified as gross income even though there is no applicable statutory exclusion. For example, the Service ruled in 1921 that passes issued by a railroad company to its employees and their dependents, to be used when not on company business, did not result in gross income.

O.D. 946, 4 C.B. 110 (1921). In Rev. Rul. 59-58, 1959-1 C.B. 17, the Service ruled that merchandise of nominal value, such as turkeys, hams, and similar items, could be distributed as Christmas gifts by an employer to his employees without income tax consequences to the employees. It has also been held that the recipient of a low-interest or interest-free loan from his employer is not in receipt of gross income. *Dean v. Commissioner*, 35 T.C. 1083 (1961), *nonacq.* 1973-2 C.B. 4; *Zager v. Commissioner*, 72 T.C. No. 82 (Sept. 5, 1979); *Creel v. Commissioner*, 72 T.C. No. 97 (Sept. 25, 1979). (For the sake of convenience, references in this discussion to "fringe benefits" relate only to those benefits which are not specifically dealt with by statute under present law.)

The absence of a clear statement of the principles which distinguish taxable fringe benefits from those which are not taxable has resulted in inconsistent administration of the statute. In some cases the taxation of fringe benefits has received great emphasis in the audit process, while in others the question of fringe benefits has not been raised. The uncertainty caused by the absence of guidelines and the uneven administration of the statute forces taxpayers to resort to speculative determinations in planning and reporting benefits arising out of the performance of services.

The question of fringe benefit taxation has drawn increasing interest during the last four years from both the executive and legislative branches of government. In September, 1975, a "discussion draft" of proposed regulations relating to the taxation of fringe benefits was published in the Federal Register. 40 Fed. Reg. 41118 (1975). These draft regulations were described as an attempt to rationalize the existing treatment of fringe benefits and to provide additional rules for the future. In general, the discussion draft would have continued the tax exempt status of a number of fringe benefits, but would have required taxation of certain benefits which are typically provided at the executive level and involve substantial amounts.

No action was taken with respect to the discussion draft until December, 1976. At that time, the Service submitted a package of draft revenue rulings dealing with the fringe benefit question for Treasury Department review. The draft revenue rulings would have represented a significant departure from the direction taken in the discussion draft of proposed regulations. The revenue rulings were never issued, and the discussion draft was withdrawn.

In March, 1977, the Commissioner of Internal Revenue stated that proposed regulations dealing with fringe benefits would be issued the following summer. As a result, a number of bills intended to prevent the Service from issuing regulations or rulings concerning fringe benefits were introduced in the Congress. No fringe benefit regulations or rulings were issued, presumably as a result of the expressed congressional interest, and the freeze was formalized in Pub. L. No. 95-427 (Oct. 7, 1978), which initially prohibited the issuance of (1) final regulations before January 1, 1980, or (2) proposed or final regulations which have an effective date before January 1, 1980, on the subject. The freeze was extended until June 30, 1981 by Pub. L. No. 96-167 (Dec. 29, 1979).

Congressional interest in the subject of fringe benefits was also evidenced by the creation of a Task Force on Employee Fringe Benefits by the Ways and Means Committee in June, 1978. The Task Force went out of existence on January 2, 1979, without making any specific recommendations; however, the Task Force did submit a discussion draft and report prepared by its staff to the Chairman of the Ways and Means Committee. Under this staff report, a fringe benefit would be excludible from income if it met any one of several tests, including (1) a "convenience of the employer" test, (2) a *de minimis* test, or (3) a "general guidelines" test involving nondiscrimination, marginal costs, and value received by the employee.

In April of 1979, the Federal Taxation Division of the American Institute of Certified Public Accountants (AICPA) published *Fringe Benefits: A Proposal for the Future*, recommending that legislation be enacted to exclude from taxation benefits which exist incidentally to an employer's business and which are provided to employees on a nondiscriminatory basis at no substantial additional cost to the employer. In addition, the AICPA proposal would exclude from taxation *de minimis* benefits, as well as benefits which (1) are considered part of the working conditions and have a proximate relation to work performed, (2) accommodate an important business requirement of the employer, or (3) are provided primarily to insure the employee's safety. If a fringe benefit is includible in income, the AICPA proposal recommends that it be valued at the lower of its incremental cost or fair market value. However, if the benefit is provided primarily for the personal use of the employee, allocated cost would be substituted for incremental cost. The AICPA proposal would apply only to common-law employees and not apply to independent contractors or partners.

The Recommendation has been prepared with the conviction that, although reasonable opinions differ greatly on how best to treat fringe benefits, the American Bar Association ought at this time to play a part in the current process of developing new rules in the area. The underlying principle of the Recommendation is that not all items of economic benefit received in connection with the performance of services should be considered gross income for tax purposes. Notwithstanding the broad language of section 61 and certain statements made by the Supreme Court in such cases as *Commissioner v. Smith*, 324 U.S. 177 (1945), there appears to be general agreement among those who have considered the subject that some items received in the employment context should be excluded from gross income. The Recommendation represents an effort to distinguish between taxable and nontaxable fringe benefits on a basis which meets the objectives of simplicity, ease of administration, and fairness. The existence of long-established practices with respect to certain fringe benefits has also been given major weight in developing the Recommendation, primarily in cases where an abrupt departure from such a practice might be especially unfair to taxpayers who might have relied upon the established tax treatment of those benefits.

The Recommendation establishes a general rule under which a fringe benefit would be included in gross income unless it is covered by one of four specific exclusionary rules and prescribes the method of valuing includible fringe benefits. Under the first exclusionary rule, a fringe benefit would be excludible from gross income if it is incident to the employer's trade or business, it is provided on a nondiscriminatory basis, and the marginal cost of providing the benefit is insubstantial. Second, a fringe benefit would also be excluded from gross income if it is provided primarily for the benefit of the employer rather than the employee. Third, a fringe benefit would be excludible from gross income if the expense of supplying the benefit is excepted from the requirements of section 274(a) by section 274(e)(5). Finally, the value of a fringe benefit would not be includible in an employee's gross income if the benefit is of insubstantial value and is not provided on a frequently recurring basis.

If a fringe benefit does not meet one of the standards for exclusion, the amount includible in gross income would equal the excess of the fair market value of the benefit over the amount paid therefor.

The first exclusionary rule established by the Recommendation is for benefits which are incident to the employer's trade or business and are available without any substantial marginal cost to the employer. The underlying rationale for this exclusion is that it is inappropriate to impose a tax based on prevailing market values on an employee who simply avails himself of goods or services which are available because of the nature of the employer's business. In many such cases the subjective value of the fringe benefit to the employee is substantially less than its fair market value, and the principal effect of imposing a tax on the basis of the fair market value of such a benefit is to discourage employees from enjoying the benefit. A benefit not incident to the employer's business, however, is clearly much more likely to be intended as compensation, and is also more likely to be provided as a result of pressure from employees to whom the subjective value of the benefit more closely approximates its fair market value. The potential for abuse of this exclusion is limited by the requirement that the marginal cost incurred by the employer in providing all such benefits may not be substantial in relation to the total cash compensation paid to all employees eligible to receive the benefits and by the requirement that the benefit be made available on a nondiscriminatory basis.

An employee's receipt of a service provided by an employer is considered incident to the business of the employer if such service is provided primarily to persons dealing with the employer in the ordinary course of its business, or if it is available because it is necessary or appropriate to the accomplishment of the employer's business objectives. An employee's receipt or use of a good or a facility made available by an employer is considered incident to the employer's business if such good or facility is owned or controlled by the employer for purposes necessary or appropriate to the conduct of its trade or business rather than primarily for the personal benefit of employees. Whether a fringe benefit is incident to the business of the employer is, of course, a question of fact to be determined on a case-by-case basis.

The marginal cost of a fringe benefit is the incremental cost incurred by the employer in providing the benefit. Stated another way, the marginal cost of a fringe benefit is the cost incurred by the employer which would not have been incurred but for the fact that the benefit was provided. The marginal cost of a fringe benefit does not include any loss of revenue actually or potentially suffered by the employer as a result of providing the benefit. In accordance with generally accepted principles of economics and accounting, fixed costs are not ordinarily included in the computation of the marginal cost of a fringe benefit. Instead, marginal cost is determined by reference to the variable (or direct) costs associated with the fringe benefit, under regulations to be developed by the Service. Fixed costs are, however, included in determining the marginal cost of an inventory item provided to an employee as a fringe benefit if such costs are included in the cost of inventory pursuant to the method of accounting used by the employer for tax purposes.

Even though a benefit is incident to the employer's trade or business, it would not be excluded from gross income under the Recommendation unless it is made available to a reasonable classification of individuals established by the employer. The establishment of reasonable classifications would be permitted in recognition of the fact that it may be inappropriate to make certain benefits available to all individuals. Whether a classification is reasonable would be judged by reference to all the facts and circumstances, but it is expected that such factors as age, length of service, and job classification may be taken into consideration. A classification would not be considered reasonable, however, if its effect would be to discriminate in favor of officers, shareholders or other owners, or highly compensated individuals.

Items provided primarily for the benefit of the employer rather than that of the employee would be excluded from gross income because such items are generally not compensatory in nature. The fact that an employee might derive some incidental personal benefit or enjoyment from such a benefit should not result in its value being included in his gross income.

Whether a fringe benefit is provided primarily for the benefit of the employer is a question of fact which would require an analysis of all of the circumstances under which the benefit is provided. No single fact or combination of facts would be conclusive. Among the factors that should be taken into consideration are whether the benefit is available to a broad cross-section of employees, is basically a condition of employment, and whether the benefit is intended primarily to facilitate the accomplishment of the employer's business objectives other than the objective of paying compensation.

The proposed statutory language does not enumerate specific benefits covered by the benefit-of-the-employer rule. A number of benefits, however, are believed generally to fall within the scope of the exclusion. For example, the provision of bodyguards and transportation to and from job sites through dangerous areas would be nontaxable to the employee because of the employer's need to protect its personnel. Employment agency fees paid by an employer would be nontaxable because such fees are intended not as compensation to the employee, but instead as compensation to the employment agency for providing the employer with necessary employees. Supper money provided by an employer for employees who occasionally work abnormal hours would be considered nontaxable because it is provided primarily to secure needed services at an unusual hour, rather than to compensate the employee for such services. The value of employer-provided training and education which is job-related would be excludible from gross income because such benefits are provided by the employer primarily to improve the conduct of the employer's business.

The third exclusionary rule under the Recommendation is that any benefit exempt from the requirements of section 274(a) by section 274(e)(5) would not be included in gross income. Section 274(a) generally disallows a deduction for any expense incurred in connection with activities involving entertainment, amusement, or recreation, unless the taxpayer establishes a close relationship between the expenditure and his trade or business. With certain exceptions, expenditures incurred for a facility used in connection with such an activity are disallowed without regard to the relationship between the use of the facility and the employer's business. Section 274(e)(5), however, exempts from the rules of section 274(a) expenses for recreational, social, or similar activities (including facilities therefor) primarily for the benefit of employees. In order to come under the ambit of section 274(e)(5), the activity or facility must primarily benefit those employees who are not officers, shareholders or other owners, or highly compensated individuals. In view of the fact that these benefits have previously been singled out for special treatment in determining the employer's deduction, it is deemed appropriate also to provide for special treatment in determining the tax consequences of their receipt.

Benefits of nominal value would be excludible from gross income because the cost to employers and employees of accounting for such benefits and the cost to the government of enforcing a policy of inclusion is not justified in view of the small amount of additional tax revenue involved. There is widespread agreement that such an exclusion is both necessary and appropriate, and the only disagreement concerns the details of such an exclusion. Under the Recommendation, a benefit would be considered to be of nominal value, and thus nontaxable, if its fair market value either is not more than fifty dollars or is so small as to make accounting for it unreasonable or administratively impractical. In order to prevent abuse, the Recommendation also provides that a benefit cannot be provided on a frequently recurring basis and remain exempt under the *de minimis* rule. Consideration was given to the imposition of an aggregate annual limitation of five hundred dollars for *de minimis* benefits, but this approach was rejected because it would have defeated the purpose of the *de minimis* exclusion by making it necessary to account for all benefits of nominal value to determine whether the aggregate limitation had been exceeded. Of course, whether a benefit is provided on a frequently recurring basis during the taxable year is a question of fact which must be determined on a case-by-case basis.

A number of other possible exclusions were considered but were omitted from the final text of the Recommendation. A proposed exclusion for benefits tending to promote socially desirable objectives was omitted because of the difficulty of defining which objectives would fall within it. An exclusion for such benefits as might be specified in regulations to be issued by the Secretary was omitted because of the belief that it would constitute an inappropriate delegation of legislative authority to the executive branch.

A fringe benefit that does not fall within one of the four categories of excludible benefits discussed above would be includible in gross income.

The selection of a valuation method to determine the amount includible in gross income has proved the most controversial aspect of the subject of taxation of fringe benefits. The two methods with the firmest theoretical and practical foundation are marginal cost and fair market value.

Marginal cost has not been in general use as a method of valuation for tax purposes. In the case of subsidized employee cafeterias, however, the Service has assessed deficiencies based on gross income measured by the excess over receipts from employees of the cafeteria's costs of operation, rather than by the excess over receipts of the fair market value of meals served. Although it cannot be said that marginal cost is always easily determinable, it may, in some cases, be easier than fair market value to determine objectively. In most instances cost information is readily available from an employer's books and records. The ability to make an objective determination is particularly important to the employer, since it is the employer who must implement any withholding or reporting requirements applicable to a fringe benefit. The cost to an employer of providing a fringe benefit is, moreover, especially relevant to the question whether the benefit is more in the nature of a nontaxable gift than taxable compensation, since in determining whether to make a gift to employees, the employer is likely to be more concerned with the cost incurred than with the economic value of the benefit to the employee. Moreover, if an item can be provided at little or no cost it is less likely to be compensatory in nature.

The determination of "fair market value," on the other hand, is often difficult and frequently results in controversy and litigation. The fact that many fringe benefits have no close counterpart in the marketplace simply aggravates the difficulty of determining fair market value. The use of a fair market value standard of valuation, however, has the virtue of being consistent with the method traditionally applied for most other purposes under the Code. To the extent that receipt of a fringe benefit is equivalent to the receipt of cash compensation, the imposition of a tax based on the amount that the recipient would have to pay for the benefit on an arm's-length basis is not unfair. Applying a fair market value standard usually results in a higher taxable amount than applying a marginal cost standard.

Recognizing that persuasive arguments can be made in support of either the fair market value method or the marginal cost method, and giving due consideration to the objectives of ease of administration, consistency with other Code provisions, and fairness among taxpayers, the Recommendation provides that a fringe benefit would be valued at fair market value both for purposes of determining whether the benefit is excludible under the *de minimis* rule and for purposes of determining the amount includible in gross income with respect to a taxable fringe benefit.

The Recommendation provides that an employee or his beneficiary must actually receive a fringe benefit in order to be taxable with respect to it. Accordingly, an employee would not be deemed to be in constructive receipt of gross income simply because a fringe benefit was available; rather, he would have to make use of the benefit before he would be required to report additional gross income.

The Recommendation would apply to any fringe benefit provided in connection with the performance of services, not merely to benefits provided by an employer for its common-law employees. Thus, benefits received by an independent contractor would be taxable in accordance with the principles of the Recommendation, as would be any benefits received by the family or friends of the individual who performed services for the employer which provided the fringe benefit. Such treatment is, of course, consistent with the principles of section 83. The Recommendation would also apply, under regulations to be issued, to benefits provided by an employer to employees of another employer in the same or a related industry under an agreement or established practice. In addition, the Recommendation provides for the issuance of regulations determining the extent to which the term "employer" shall be limited to a particular business of the employing person "such as a division" or expanded to include persons related to the employing person within the meaning of section 482.

The Recommendation would also apply to a fringe benefit received by a partner from his partnership. Regulations should be issued to clarify the fact that an includible fringe benefit is to be treated as a guaranteed payment under section 707(c).

The Recommendation is not intended to have any effect upon the tax treatment of any fringe benefit which is specifically dealt with by another provision of the Code, qualified plans, group term life insurance, health and accident plans, and legal services plans. In addition, any benefit which constitutes a transfer of property and which is not excludible under the Recommendation would remain subject to section 83.

The Recommendation relates only to the amount of income required to be recognized by the employee. Any deduction available to an employer would continue to be governed by existing provisions of the Code and regulations. Accordingly, the employer's deduction generally would equal the costs incurred in providing a fringe benefit.

As noted above, the Recommendation does not attempt to specify the tax treatment of particular fringe benefits. Although specific treatment of particular benefits might result in somewhat greater certainty with respect to those particular benefits, it is not possible to anticipate, and thus deal with, all of the possible items which might now or hereafter be provided as fringe benefits. Moreover, a fringe benefit might properly be taxable under some circumstances, but not others. Accordingly, the Recommendation is limited to a statement of general principles under which the tax consequences of the receipt of a fringe benefit are to be determined.

The proposed statutory language does not deal with the withholding questions which arise in connection with fringe benefits, but it is recommended that includible fringe benefits not be subject to withholding or other payroll tax requirements. However, the fair market value of any includible fringe benefits should be reportable as "other income" on Form W-2 or, with respect to nonemployees, on Form 1099 or Schedule K-1, as appropriate. Improper reporting or nonreporting should be subject to appropriate penalties (higher than existing law) either in the form of appropriate monetary penalties or, in aggravated cases, disallowance of deductions.

The general approach of the Recommendation is very similar to the proposals of the Joint Staff Task Force and the Federal Tax Division of the AICPA. However, the Recommendation differs from these two proposals in several important respects. The principal differences between the Recommendation and the Joint Staff proposal are that the Recommendation does not provide for an overall "insubstantial" limitation on excludible benefits. The principal difference between the Recommendation and the AICPA proposal is that the Recommendation would value all includible benefits at fair market value rather than the lower of cost or value as under the AICPA proposal. Further, the AICPA proposal defines benefits which are incident to the employer's business more narrowly than the Recommendation to include only facilities, goods and services which are produced, held for sale or furnished to the employer's customers. In addition, the AICPA proposal applies only to common-law employees and not independent contractors and partners. The Recommendation also differs from the two other proposals by providing a specific fifty dollar limitation in addition to the more subjective *de minimis* standard.

The Section of Taxation has no earlier recommendation that is related to this Recommendation.

No member of the originating committee or of the Council of the Section of Taxation is known to have a material interest in the Recommendation by virtue of a specific employment or engagement to obtain the result of the Recommendation. It is recommended that the amendment be given only prospective application. In that case, clients would not be affected in any pending matter.

CHARLES M. WALKER, *Chairman*

Appendix B

APPLICATION OF PRESENT LAW AND TAX SECTION LEGISLATIVE RECOMMENDATION TO THE TAXATION OF SPECIFIED FRINGE BENEFITS

Example (1). A commercial airline makes transportation passes available to all of its employees. A nominal service charge is imposed for each pass. A pass entitles the employee, or any member of the employee's family, space-available transportation on any regularly scheduled flight of the airline. The number of passes available to an employee depends on his or her length of service. Upon completion of three years of service, an employee is entitled to an unlimited number of passes.

Present Law. The value of these passes is potentially subject to taxation under section 61 of the Code. Administratively, the value of such passes is generally considered excludible from the employee's gross income under an extension of O.D. 946, 4 C.B. 110 (1921), the Treasury ruling dealing with railway passes.

Tax Section Recommendation. The value of the transportation passes is excludible from the employee's gross income under subsection (b) of the Recommendation. The benefit is "incident" to the employer's business because it consists of the use of property owned or controlled by the employer primarily for purposes necessary or appropriate to the conduct of its business, other than the purpose of paying compensation. Since the employees travel only on regularly scheduled flights, on a space-available basis, the marginal costs of providing the personal service benefit is insubstantial. Finally, the personal service benefit is made available in a nondiscriminatory manner. The value of any passes made available to a family member is also excludible, because of the broad definition of "personal service benefit" in subsection (f)(1) of the Recommendation.

Example (2). All of the employees of a law firm are entitled to free parking at a garage located near the law firm's downtown office. The law firm pays the garage a monthly fee based upon the number of employees who have parking privileges for the month. Each employee who wishes to take advantage of this benefit is issued a parking permit identical to that issued to other individuals who contract for parking on a monthly basis.

Present Law. The fair market value of the parking privilege would be includible in the gross income of each employee to whom a parking permit is issued under section 61 of the Code.

Tax Section Recommendation. The fair market value of the parking privilege is includible in the gross income of each employee to whom a parking permit is issued. The benefit is not incident to the employer's trade or business; nor does it qualify for exclusion under any other provision of the Recommendation. The fair market value of the parking rights is determined by reference to the customary price charged by the garage to its monthly contract customers.

Example (3). An automobile manufacturer employs 10,000 individuals at an assembly plant located on the outskirts of a metropolitan area. Because sufficient public parking is unavailable, the automobile manufacturer constructed and maintains a large parking lot adjacent to its plant for the use of its employees. No charge is levied for such use.

Present Law. The value of this free parking is potentially subject to taxation under section 61 of the Code, although an argument could be made under existing case law that the value of parking is not subject to tax because the parking is essentially a working condition which is provided primarily for the convenience of the employer. Furthermore, the value of this benefit might be viewed as de minimis. Historically, the Internal Revenue Service has not attempted to tax this specific benefit.

Tax Section Recommendation. The value of the free parking provided to the employees is excludible under subsection (c) of the Recommendation. Under the facts and circumstances, the parking facility is provided primarily for the benefit of the employer. The absence of adequate public parking makes it necessary for the employer to provide parking in order to obtain the services of the needed number of employees.

Example (4). A corporation maintains an airplane for the use of its executives on company business. The corporation also permits executives who are not engaged on company business to occupy a seat on a business flight if that seat would otherwise be unoccupied.

Present Law. The fair market value of the flight of the hitchhiking employee is potentially subject to taxation under section 61 of the Code. This treatment is supported by the Joint Committee on Internal Revenue's report on the Examination of President Nixon's Tax Returns for 1969-1972, 93rd Cong., 2d Sess., at 157-168 (Washington: U.S. Government Printing Office, 1974). The value of the flights in the Nixon case was established with reference to the equivalent first-class airfare. The Internal Revenue Service has not been aggressive in seeking to tax flights made on a space-available basis.

Tax Section Recommendation. The fair market value of the flight is includible in the gross income of an employee who hitches a ride on the corporate aircraft for nonbusiness reasons. The opportunity to use the aircraft for personal purposes is made available only to a classification which discriminates in favor of officers, shareholders, or highly compensated individuals, and thus the value of the benefit is not excludible under subsection (b) of the Recommendation. The fair market value of the flight must be determined on the basis of all the facts and circumstances.

Example (5). An international corporation provides bodyguards to certain of its executives living or traveling in countries where terrorist acts are a realistic threat.

Present Law. The fair market value of the bodyguards is potentially subject to taxation under section 61 of the Code, although a strong argument can be made under existing case law that the value of bodyguards is not subject to taxation because the bodyguards are essentially a working condition provided primarily for the benefit of the employer. The Internal Revenue Service has not attempted to tax this specific benefit.

Tax Section Recommendation. An executive who is provided with a bodyguard is not required to include the value of such services in its gross income. The bodyguard is deemed to be provided primarily for the benefit of the employer, since the employer has an overriding business reason to maintain the safety of its key employees. Although the employee has an obvious and substantial interest in his own safety, the personal benefit derived from the bodyguard's services is incidental to the primary business purpose of the employer.

Example (6). An oil company maintains an employees' country club. All employees of the corporation are entitled to use of the club's facilities upon payment of nominal monthly dues. A substantial majority of the employees who are members of the country club are not officers, shareholders, or highly compensated individuals.

Present Law. The fair market value of the use of the country club's facilities is potentially subject to taxation under section 61 of the Code. Historically, the Internal Revenue Service has not attempted to tax these type of benefits.

Tax Section Recommendation. An employee is not required to include the fair market value of the use of the country club's facilities in gross income. The employer's deduction with respect to the facility is not subject to the requirements of section 274(a) pursuant to the provisions of section 274(e)(5), and the benefit is thus excludible under subsection (b) of the Recommendation.

Example (7). A corporation which owns and operates a hotel in a resort area provides rooms to travel agents at a substantial discount from the regular rate. The travel agents are not employees of the corporation which owns and operates the hotel.

Present Law. The excess of the fair market value of the hotel room over the amount paid is potentially subject to taxation under section 61. Administratively, the Internal Revenue Service has not been aggressive in seeking to tax benefits of this nature.

Tax Section Recommendation. The excess of the fair market value (i.e. the regular rate) of the hotel room over the amount paid by a travel agent is includible in the travel agent's gross income. Under subsection (f)(2) of the Recommendation, the hotel operator is not the employer of the travel agent. Accordingly, none of the exclusions set forth in the Recommendation apply. It should be noted, however, that the Service is authorized to prescribe regulations which would permit a person engaged in the same or a related trade or business as the person for whom services are performed to be treated as the employer of the person rendering services. Thus, the Service could issue regulations which would permit the hotel corporation to be treated as the employer of a travel agent, in which case the value of the benefit would be excludible under subsection (b) of the Recommendation if it were provided in a nondiscriminatory manner.

Example (8). A retail clothing store permits all of its employees to purchase any merchandise held for sale to customers at a discount of 30% from the regular retail price. In some individual cases the discounted price is less than the wholesale price paid for the merchandise by the employer, but the average discount price exceeds the average wholesale price for all items of merchandise purchased by employees.

Present Law. The value of the discount is potentially subject to taxation under section 61 of the Code. Administratively, the Internal Revenue Service has not attempted to tax such benefits.

Tax Section Recommendation. None of the employees are required to include any amount in income as a result of the purchase of merchandise at a discount. The discount constitutes a personal service benefit which is incident to the employer's trade or business, and it is made available on a nondiscriminatory basis. Although the marginal cost of certain items of merchandise exceeds the discounted price paid for those items, the employer's marginal cost of providing all benefits of the same character to all recipients during the taxable year is zero.

Example (9). An employer purchases season tickets for the home games of the local professional basketball team. The tickets are used for the purpose of entertaining customers and business associates, and the cost of the tickets is properly deductible under sections 162 and 274. Employees typically accompany the employer's business associates and customers at the games.

Present Law. The value of the use of tickets by the employees is not considered to be includible in gross income, provided there is a proper business purpose (e.g. client entertainment) associated with the use.

Tax Section Recommendation. The employees who attend the basketball games in connection with entertaining the employer's customers and business associates are not required to include the value of their tickets in gross income. The tickets are provided primarily for the benefit of the employer. Any personal pleasure derived by the employee from attending the basketball game is merely incidental to the employer's business purpose in furthering its relationship with its associates and customers.

Example (10). An automobile dealer provides "demonstrator" automobiles for use by its salesmen. The salesmen are entitled to use the demonstrators for commuting and other personal purposes without any obligation to reimburse the employer with respect to such use.

Present Law. The value of the personal use of the automobiles is subject to taxation under section 61 of the Code. See, e.g., Dole v. Commissioner, 351 F.2d 308 (1st Cir. 1965), aff'g per curiam 43 T.C. 697 (1965).

Tax Section Recommendation. The fair market value of the personal use of the demonstrator automobiles is includible in the gross income of the salesmen under subsection (a) of the Recommendation. The benefit to the employee from using the automobile for commuting and other personal purposes is more than merely incidental to the employer's business purpose in making the car available. (The employer's business purpose is sometimes stated to be the advertising value derived from having the automobile on the road and thus in public view).

Example (11). An employer provides Christmas gifts, such as bottles of inexpensive perfume, pen and pencil sets, etc., to its employees.

Present Law. The value of de minimis Christmas gifts has been held to be excludible from gross income by Rev. Rul. 59-58, 1958-1 C.B. 17.

Tax Section Recommendation. The value of the Christmas gifts is excludible from gross income under subsection (e) of the Recommendation. The fair market value of each gift is less than $50, and the benefit is not provided on a frequently recurring basis during the taxable year.

Example (12). A law firm will prepare a will for any employee or partner who has completed one year of service. No charge is imposed for this service.

Present Law. The value of this service is potentially subject to taxation under section 61 of the Code. Administratively, the Internal Revenue Service has not attempted to tax benefits of this nature in the past.

Tax Section Recommendation. No amount is required to be included in income with respect to the preparation of a will for an employee or partner of the law firm. The benefit is incident to the employer's trade or business, the marginal cost of providing the benefit is insubstantial in relation to the compensation paid to the individuals eligible to receive the benefit, and the benefit is made available in a nondiscriminatory manner. If the benefit were made available only to partners in the law firm, the value of the service would be includible in the gross income of a partner for whom a will was prepared, because the classification of individuals eligible for the benefit would be discriminatory in favor of owners and highly compensated individuals.

Example (13). A university permits the children of members of its faculty to attend the university without charge. In addition, the children of the faculty members may attend certain other universities without charge under reciprocal agreements with such other universities.

Present Law. Amounts paid under tuition remission programs are considered nontaxable scholarships under section 117 of the Code, by virtue of Treas. Reg. § 1.117-3(a). In 1976, the Treasury attempted unsuccessfully to withdraw this regulation and tax amounts paid under tuition-remission plans. The attempted withdrawal was revoked in early 1977.

Tax Section Recommendation. A faculty member is not required to include any amount in gross income with respect to his child's tuition-free attendance at the university by which he is employed, provided that the limitation of the benefit to members of the faculty does not result in discrimination in favor of highly compensated individuals. Whether or not such discrimination results must be determined on the basis of all the facts and circumstances. If no such discrimination exists, the benefit is excludible under subsection (b) of the Recommendation, because the benefit is incident to the employer's trade or business and no substantial marginal cost is incurred by the employer in making the benefit available. (Of course, it is assumed that it is unnecessary to hire additional faculty members or to increase the size of the facilities to accommodate the children of faculty members.)

The value of the free tuition is includible in the faculty member's gross income if it is determined that the benefit is provided to a classification of employees which discriminates in favor of highly compensated individuals. In addition, a faculty member must include in gross income the value of his child's tuition-free attendance at another university, regardless of whether the benefit is provided in a discriminatory manner. The other university is not considered the faculty member's employer under the Recommendation, and thus none of the exclusionary provisions apply. As previously noted, however, the Service is granted the authority to broaden the definition of the term "employer", and thus bring tuition remission programs under reciprocal agreements within the ambit of the exlusionary rule set forth in subsection (b) of the Recommendation.

Example (14). A company provides a chauffeur-driven automobile for transportation to and from work for each of its officers. The cars also are available to the officers during the day for trips to and from business appointments.

Present Law. The fair market value of the transportation to and from work would be includible in the gross income of each officer to whom the automobile is furnished. That portion of the use allocable to transportation to and from business appointments would not be subject to taxation.

Tax Section Recommendation. The fair market value of the transportation to and from work is includible in gross income. The opportunity to use the limousines is made available only to a classification which discriminates in favor of officers, and thus the value of the benefit is not excludible under subsection (b) of the Recommendation. Further, the cost of furnishing these automobiles and drivers undoubtedly would be considered substantial. The value of that portion of the use allocable to transportation to and from business appointments would be considered as being provided primarily for the benefit of the employer primarily for the benefit of the employer and not taxable under subsection (c) of the Recommendation.

Example (15). A large company with its corporate headquarters adjacent to its plant in an industrialized area of a large city maintains a dining room for its executives in order to permit them to conduct business luncheons among themselves and outside persons with whom the corporation transacts business. The dining room is open to all executives above a certain level which includes some non-officers. The executives are required to pay for their own meals and the price of the meals are established to recover the full costs of operating the dining room facility.

Present Law. The excess of fair market value over the cost of the meals is potentially subject to taxation under section 61 of the Code. The Internal Revenue Service has not been aggressive in seeking to tax this benefit, presumeably because of the administrative burdens and the existence of the argument that it serves the business needs of the employer to have its executives take their meals in this facility.

Tax Section Recommendation. The dining facility arguably is necessary and appropriate to the employer's business and, thus, incident to its trade or business. The meals are furnished at no additional cost to the employer and are made available on a nondiscriminatory basis to a reasonable class of employees which includes some non-officers. Thus, the bargain portion of the meals should be excludible from gross income under subsection (b) of the Recommendation.

Example (16). A manufacturing company maintains a cafeteria which is open to all employees and which serves meals at prices established to cover the full costs of operating the cafeteria. The company's plant is located adjacent to the downtown area of a large facility where adequate eating facilities are available.

Present Law. The excess of the fair market value over the cost of the meals is potentially subject to taxation under section 61 of the Code. The Internal Revenue Service has not been aggressive in seeking to tax this benefit, presumeably because of the administrative burdens.

Tax Section Recommendation. The cafeteria would not be considered to be incident to the employer's business because of the existence of nearby alternate eating facilities. Thus, the benefit would not be excludible under subsection (a). The benefit might be considered de minimis and excludible under subsection (e) on the ground that it is so small as to make accounting for it unreasonable and administratively impractical except for the fact that the benefit would presumeably be received by employees on a frequently recurring basis.

Senator **Wallop**. Thank you, Mr. Aidinoff. I only have one, and that is: Given your freeze or your grandfathering of your existing contract benefits, and your criteria for taxation or nontaxation of any other benefits, would you leave that open-ended ad infinitum as long as they qualified under the outlined circumstances.

Mr. **Aidinoff**. We would apply the tests in our proposal both to past benefits and to future benefits. We really do not see an abuse when we are talking about nondiscriminatory benefits related to an employer's trade or business.

Senator **Wallop**. But that slightly begs my question. As long as they met your criteria would you have that open-ended?

Mr. **Aidinoff**. I don't know what you mean by the word open-ended.

Senator **Wallop**. Well, I mean is there no limit to what could be——

Mr. **Aidinoff**. We would have no cap on that type of benefit.

Senator **Wallop**. No matter what?

Mr. **Aidinoff**. No matter what. We don't think that is an abusive situation.

Senator **Wallop**. You can't conceive of a circumstance under which it would be?

Mr. **Aidinoff**. I think that when we reach that type of situation and have evidence of that type of abuse, at that point a cap might be appropriate. But the present feeling is that it is more important to have a general rule, and the fact that one aspect of the rule is that it be nondiscriminatory and not be provided at any additional cost, I think provides the necessary protection of the Treasury.

In other words, I am not going to distinguish between a professor who has six children of college age and one that has one.

Senator **Wallop**. As a total percentage of income, ever?

Mr. **Aidinoff**. No. Not on that type of benefit.

Senator **Packwood**. Mr. Aidinoff, as I understand it, you've got a three-pronged test plus this definition of recreational facilities. First, it's excludable if it meets a three-pronged test of incident to business, nondiscriminatory, and incremental cost—that's all one test?

Mr. **Aidinoff**. Right. That's all one test.

Senator **Packwood**. The second test: Excludable if it is primarily for the benefit of the employer—the logging supplying lunches that are provided to employees 50 miles up in the woods because there is no place to go for lunch, I assume that's the kind of thing you are talking about? That it is insubstantial and provided infrequently?

Mr. **Aidinoff**. Yes. That would be the Christmas turkey.

Senator **Packwood**. Although if they gave it every year it would be at least recurring consistently.

Mr. **Aidinoff**. Well, yes. But one turkey a year would be all right. [Laughter.]

Senator **Packwood**. Well, I wish we had the same standard in Congress.

Mr. **Aidinoff**. One turkey and one ham might give us difficulty. [Laughter.]

Senator **Packwood**. Now, tell me about the employer furnished recreational facilities so I understand before I ask my next question.

Mr. **Aidinoff**. Well, let's assume that we have a country club facility which is made available to all employees. That would be an example of a recreational facility.

Senator **Packwood**. So basically the ABA is coming down more or less on the Stanley Surrey side that the Tax Code should not be used for social purposes.

Mr. **Aidinoff**. Yes.

Senator **Packwood**. So that health care would be taxable from dollar-zero.

Mr. **Aidinoff**. No. Our proposal does not deal with statutory fringe benefits at all.

Senator **Packwood**. Oh.

Mr. **Aidinoff**. I mean, our proposal does not deal with medical benefits, legal benefits, or anything else. What we are talking about is how you handle the airline pass, how you handle the chauffeur, how you handle the free lunch, and items like that. And remember, most of those would be taxable under our proposal.

Senator **Packwood**. All right. Let me ask you just out of curiosity about the airlines—the flight attendants who travel free when the plane is half-loaded, is this incident to the employer's trade or business? It seems to me it is.

Mr. **Aidinoff**. It clearly is.

Senator **Packwood**. Though it is nondiscriminatory, and the incremental cost is next to nothing, because the plane is flying anyway.

Mr. **Aidinoff**. That is correct. We would say that under those circumstances we would not tax the airline stewardess.

Senator **Packwood**. It is probably the same with department store discounts to employees that are relatively marginal?

Mr. **Aidinoff**. That is correct.

Senator **Packwood**. All right.

I understand very well. You do not make any recommendations as to what ought to be included in or excluded from statutory fringe benefits?

Mr. **Aidinoff**. No. We have no recommendations on that.

Senator **Packwood**. Thank you very much.

Mr. **Aidinoff**. You are welcome.

Senator **Packwood**. I have no further questions.

Senator **Wallop**. Thank you, Mr. Aidinoff. I appreciate it.

The next is a panel consisting of Dr. James Strain, Mr. John Troy, Mr. Bernard Tresnowski, and Dr. Burton Press.

STATEMENT OF DR. JAMES E. STRAIN, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, ARLINGTON, VA.

Dr. **Strain**. Thank you, Senator.

Senator Wallop, and members of the Finance Committee, I am Dr. James Strain, and I'm president of the American Academy of Pediatrics.

The academy is an organization that represents 25,000 pediatricians in this country who are dedicated to the promotion of maternal and child health, and we appreciate the opportunity to testify this afternoon on a long-overdue reform of tax laws.

May I say at the outset that, irrespective of any final action on the tax cap itself, our judgment is that the tax laws can and should be reformed to promote a more equitable system for children with regard to employer-provided health insurance.

The fact is, current insurance plans continue to encourage hospitalization procedures and other treatment services which contribute directly to escalating health care costs while they discourage preventive care and early diagnosis of disease, both of which decrease costs.

The special tax status granted to employer-provided health insurance plans thus has created waste, inefficiency, and inflationary pressures on our health care system. It has also permitted inequities and discriminatory practices against children.

Millions of American children, including a substantial percentage of preschool children, still do not receive vaccinations for measles, rubella, mumps, polio, diphtheria, tetanus, and pertussis. Immunizations are not generally covered by private health insurance plans.

We cannot accept the argument that insurance plans do not discriminate against children because they provide benefits identical to those of adults. Children are unique. They are different. They are not small adults. Their health care needs are different than those of adults. Children under 15 require, for instance, only about one-fourth as much hospitalization as adults; but they need much more ambulatory care to promote health development and to prevent childhood diseases.

Yet, insurance plans still focus on hospitalization, at the expense of crucial preventive health services for children.

Today only about 30 percent of American children are covered for physician visits by private insurance, and this coverage generally includes only the treatment of accidents or illnesses.

In terms of costs involved, consider for a moment the American Academy of Pediatrics' long-recommended guidelines for the care of children and youth, which provide for a schedule of visits at specific times in a child's life. They offer a basis for premium cost estimates by third-party payors when combined with data on fees and charges in various communities.

The academy recently engaged an independent actuary to work with actuarials from a major insurance company to develop a model for estimating premiums necessary to cover our recommended preventive health services. The bottom line is that the total cost for providing all child health supervision services from birth to age 20 costs about the same as 1 day in the hospital.

Translated into premium costs, the average monthly premium for covering all preventive health services for children was $2.28. This compares with the $2-plus per month now being expended for illness-covered health insurance. And the premium costs for children's health supervision do not take into account the reduction in illness und hospitalization which would surely result.

In conclusion, Mr. Chairman, the academy believes that there is only one way in the long run to reverse the highly inflationary influence of illness-oriented health insurance, and that is to change the nature of the insurance to encourage prevention and early diagnosis of disease.

The place to begin is with children's coverage, where the research has shown that there will be the highest payoff. And there is only one way, considering the dominance of employer-provided health insurance, to end the inequitable provisions applying to children. That is to deny tax deduction to those plans which practice such discrimination.

Thank you.

Senator WALLOP. Thank you, Dr. Strain.

[The prepared statement of James Strain follows:]

TESTIMONY PRESENTED BY JAMES E. STRAIN, M.D. PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS

Mr. Chairman, members of the Finance Committee, I am Dr. James Strain, president of the American Academy of Pediatrics, an organization representing more than 25,000 pediatricians who are dedicated to the promotion of maternal and child health. We appreciate the opportunity to testify today on S. 640, which is viewed as a tax-reform measure. We believe that reform of the tax laws as they apply to employer-provided health insurance are long overdue. Current insurance plans encourage hospitalization, procedures and other acute services which contribute directly to escalating health care costs; they discourage preventive care and early diagnosis of disease both of which decrease costs. The special tax status granted to employer-provided health insurance plans thus has helped to create waste, inefficiencies and inflationary pressures on our health care system. It also has permitted shameful inequities and discriminatory practices against children.

TAX POLICIES ARE DISCRIMINATORY

Mr. Chairman, among other cherished Constitutional goals, the Founding Fathers established a nation "to promote the general welfare." Surely we all can agree that the good health of America's children is central to promotion of the general welfare. Yet taxpayers are being forced to subsidize group health insurance plans which adversely affect the health of children.

Because of the special tax-deductible status granted them, the group health insurance plans have become the dominant method of financing personal health care services in this country. They literally have driven the system. We are all indebted to the health insurance industry for demonstrating a remarkable capability of covering more than 90 percent of all Americans who are not eligible for government programs. Particularly impressive is the extent of coverage provided under the employer-based plans; in some industries universal coverage of employees and their dependents has been achieved.

But the record of the insurance industry in meeting the personal health care needs of children is not impressive—indeed it is spotty at best. It has pulled the health care system in a direction inimical to children. While overproviding for hospitalization, surgery and procedures, it has underprovided for the essential services children need.

The problem for those of us who are directly concerned with delivering health care to children is that health insurance has erected financial barriers between the children and the services they need. Instead, it should be removing the barriers.

The insurance industry admits to certain shortcomings in its treatment of children. It says that insurance is designed to spread risks; that the types of child supervision services which are excluded from coverage are not costly; and that, therefore, they are budgetable and should be paid directly by the family. The insurance companies and the Blue Cross-Blue Shield plans contend, moreover, that they do not discrminate against children because the benefits they provide apply equally to adults and children.

The logic of the industry can be compared with the gentleman who said that Medicare is no good because, if it were, why do the people getting it look so old? In other words, the industry's purported logic is anything but.

COVERAGE EXPANDS—BUT NOT FOR CHILDREN

Health insurance, by design of the industry itself, is unique among the many lines of insurance. For more than three decades, it has developed and expanded as a form of prepayment. It has covered vision services, toenail-cutting services, dental checkups and prescription drugs. It has developed insurance for stomach aches in Mexico and for specified "dread diseases" in the United States. It has found ways of covering the services of chiropractors, optometrists, faith healers and mental health practitioners of all sorts.

The health insurance companies describe the many coverages as "innovative." They commonly boast, "we will sell anything you want." However, what they do not sell is coverage for child health care needs. They say buyers are not demanding it. But in our opinion, that does not relieve America's dominant health insurance system of the responsibility to market it. The tax laws should encourage them do to so.

Young working people with children must rely on their employer-provided health insurance even more than most older workers. The younger families generally have less income. It is often difficult to budget, with after-tax dollars, for any but the most essential costs of living, such as housing, food, clothing and transportation. If the health insurance plan excludes coverage of well-baby and child health supervision services, many families will wait for symptoms of illness to appear before bringing the child in—and that can be tragic.

MEETING NEEDS IS COST-EFFECTIVE

Millions of American children—including a substantial percentage of all preschool children—still do not receive vaccinations for measles (24.4 percent), rubella (24.8 percent), mumps (27.3 percent), polio (21.7 percent) and Diphtheria-Tetanus-Pertussis (13.1 percent). Immunizations are not generally covered.

For each dollar spent on screening Texas children for congenital malformations, eye and ear problems and preventive dental care, eight dollars were saved in long-term costs and income loss. But screening is not generally covered.

It is ironic that Medicaid provides for Early and Periodic Screening and Diagnosis (EPSDT) of eligible children, but private health insurance does not. It has been found that children screened through EPSDT in Missouri were on average 33 percent less costly to Medicaid than other children. In Ohio, they were 30 percent less costly; in North Dakota, 40 percent less, and so forth.

The argument is also illogical that the insurers do not discriminate against children because they provide benefits identical to those of adults. Children are unique. They are not small adults. Their health care needs are different from those of adults. Health insurance plans commonly cover adult needs and exclude children's needs. Children under 15 require only about one-fourth as much hospitalization as do adults, but they need much more ambulatory care. Insurance plans cover hospitalization but exclude ambulatory care.

In fact, only about 30 percent of children are covered for physician visits by private insurance. This coverage generally excludes any visits for other than acute care. Additionally, private insurance pays for only about 9 percent of services rendered during pediatric visits.

Health insurance policies seldom cover children's health care needs. For example: More than 50 percent fail to cover prenatal care; 45 percent exclude postnatal care, and 50 percent only partially cover newborns during their first days of life.

Clearly each year the health insurance industry is selling tens of billions of dollars of group health insurance that harshly discriminates against children. And the tax laws are subsidizing the premiums paid for such defective and discriminatory policies.

CHILDREN ARE DIFFERENT

Children are different in size, metabolism, immunity, joint structure, skin, neurologic maturity, intestinal and digestive ability, brain susceptibility, emotional maturity, and more. Children are constantly growing, developing and changing. That is precisely why child health supervision is so important. It is important to prevent diseases that can be prevented. From diphtheria to measles there have been repeated unnecessary epidemics. From avoidable meningitis to Rheumatic fever recurrences, there have been untold numbers of children damaged or killed.

The question becomes, why does private health insurance fail to cover the needs of children? Is it costly to do so? Is the competition so fierce among carriers that price considerations rule out child health supervision?

There is no doubt that health insurance premiums have experienced extraordinary inflation. So rapidly have the premiums increased that employers complain of 20–40 percent annual rises or more. But surely a major cause of the inflation must be traced to the design of the policies themselves, the encouragement of unnecessary acute services and the exclusion of preventive care. An ounce of prevention may not be worth a full pound of cure, but for children the data would indicate it is worth at least a half-pound. At least 15 studies have found that preventive health care has a clear, positive effect on reducing illness and improving children's health.

Should taxpayers subsidize health insurance policies which discriminate against children and which cause imbalances and inflationary pressures in health care?

In our opinion, the answer is unequivocally NO. We hope the committee will agree. We intend to invite like-minded organizations concerned with children to join us in demanding an end to the discrimination against children. If the insurance carriers cannot measure up to the standards of need of children, then their policies should not be subsidized by taxpayers.

ROLE OF THE STATES

Let us make clear that we are not proposing federal regulation of the insurance industry. We believe insurance regulation properly belongs to the states. We are proposing tax reforms. We are calling for an end to favorable tax treatment for health insurance plans which maintain unfavorable provisions for children's health. What are the states doing about the problem? The answer is that there is very little they are doing, can do, or would be inclined to do so long as the system is driven by federal tax policies.

Two states, California and New York, passed recent legislation requiring insurers to offer or to make available minimal so-called "well-baby" coverage. Although the insurers did not contest the legislation, they by no means can be accused of marketing the new coverage with zeal. In fact, one insurance broker in California said it was "like pulling teeth" even to elicit the specifications of the "well-baby" coverage when he contacted a dozen major carriers.

State regulation of health insurance is focused mainly on solvency of the insurer and on any fraudulent practices. The insurance departments approve policy rates to assure they are reasonable in terms of covering the costs of the promised benefits. With hundreds of insurance companies offering differing gradations of benefits, generally for the same hospital, surgical and procedural services, the insurance departments seemingly have enough to do working through this mathematical labyrinth. They do not normally recommend or even suggest policy changes affecting scope of benefits. No state mandates the inclusion of child health supervision services.

To date there has been no serious attempt by insurers to tests the efficacy of benefit changes in employer-based health insurance plans. With the exception of the HMOs, which together now enroll about 5 percent of the population, very few if any plans appropriate benefits for the needs for children.

HEALTH CARE GUIDELINES AND COSTS

The American Academy of Pediatrics long has recommended guidelines for the care of children and youth. The guidelines provide for specified services at specified times in the child's life. Since each child is unique, the guidelines are not rigid, but do offer a basis for premium cost estimates by third-party payers when combined with data on fees and charges in various communities.

The Academy recently engaged an outside independent actuary to work with actuaries from a major insurance company to develop a model for estimating premiums. Using a client company with 45,930 employees, of whom 31,490 had a total of 41,167 dependent children, the actuaries applied the Academy's recommended services to calculate utilization figures per child. The Academy then surveyed pediatricians in 60 cities and elicited their charges for covering the recommended services, which we call the periodicity schedule. Pediatricians in 40 cities now have responded in sufficient detail to include in this report. The bottom line is that the total costs for providing all child health supervision services from birth to age 20 costs about the same as one day in the hospital.

Translated into premium costs, the average monthly premium for covering all the services was $2.28. This compares with the $200-plus per month now being expended for illness-covered health insurance. And the premium costs for child health supervision do not include credits for reductions in illness and hospitalization which would surely result.

CONCLUSION

Mr. Chairman, in our opinion there is only one way in the long run to reverse the highly inflationary influence of illness-oriented health insurance, and that is to change the nature of the insurance to encourage prevention and early diagnosis of disease. The place to begin is with children's coverage, where the research has shown there would be the highest payoff.

There is only one way, considering the dominance of employer-provided health insurance, to end the inequitable provisions applying to children, and that is to deny tax deductions to those plans which practice such discrimination.

We further believe that inclusion of equitable benefits for children will create incentives and impetus for an overdue redesign of health insurance plans. Compensating changes are much more acceptable to unions and employers than are cutbacks, and child health care benefits can be an attractive addition to help reduce both employer costs and the amounts deducted for health insurance from taxable income. Reductions would also occur in government health expenditures, which are driven by dysfunctional health insurance incentives.

It has been 40 years since Congress addressed the real issues of tax treatment of employer-based health insurance. Because of the laws have lacked even the most basic standards, the insurance has driven health care into what is now broadly perceived as a cost crisis. It has established financing patterns that are unfair to children and their parents.

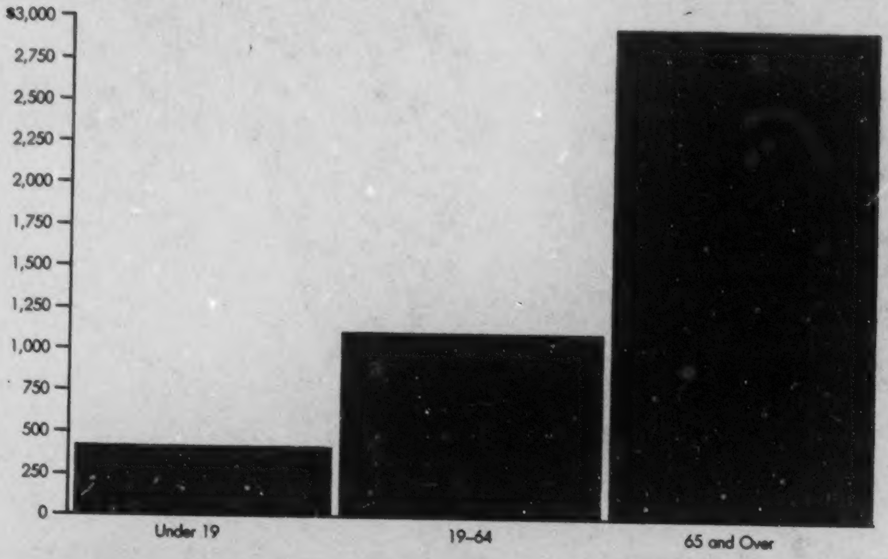
We believe the tax laws should be reformed to help create an improved and more equitable system irrespective of final action on a tax cap aimed at employer-provided health insurance.

Children Are Discriminated Against as a Result of Government Tax Subsidies

The Health Care Needs of Children, i.e., Health Supervision and Preventive Care, Have Been Systematically Excluded from Group Health Insurance. Thus Children as a Class of Citizens Have Not Received Equal Protection Under the Law.

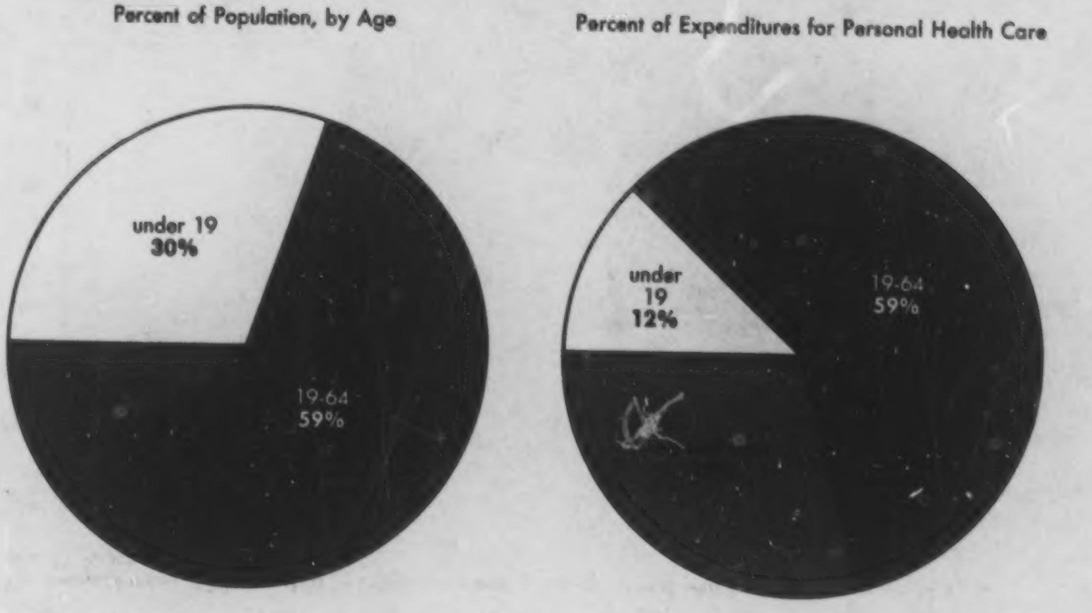
Children's Health Care Costs Less Than That of Any Other Population Group

The average medical bill per child in 1981 was about $414, compared with $1,106 for persons 19 to 64, and $2,933 for those 65 and over.



Sources: Fisher, *Health Care Financing Review*, Spring 1980.
Gibson and Waldo, *Health Care Financing Review*, September 1982.

Health Care Expenditures for Children Comprise a Small Proportion Relative to Their Population Size



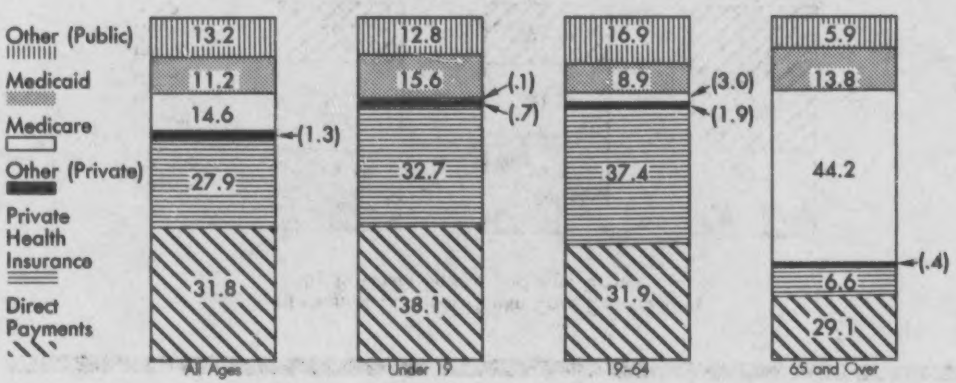
Percent of Population, by Age

Percent of Expenditures for Personal Health Care

Sources: Bureau of the Census, *Statistical Abstract of the United States*, 1980.
Fisher, *Health Care Financing Review*, Spring 1980
Gibson and Waldo, *Health Care Financing Review*, September 1982.

Most Expenditures for Children's Health Care Are Private

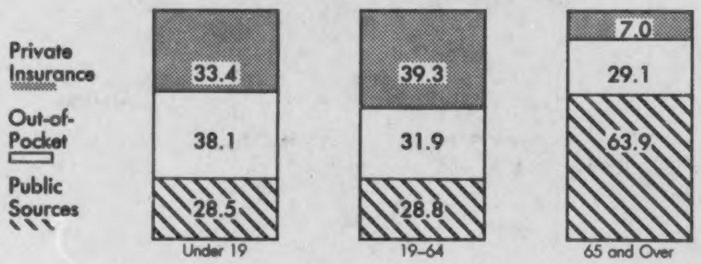
Distribution of Personal Health Care Expenditures
by Payment Source and Age Group



Source: Fisher, *Health Care Financing Review*, Spring 1980.

Private Health Insurance and Direct/Out-of-Pocket Payments Are By Far the Major Source of Payment For Children, Providing More than 70 Percent of Their Health Costs.

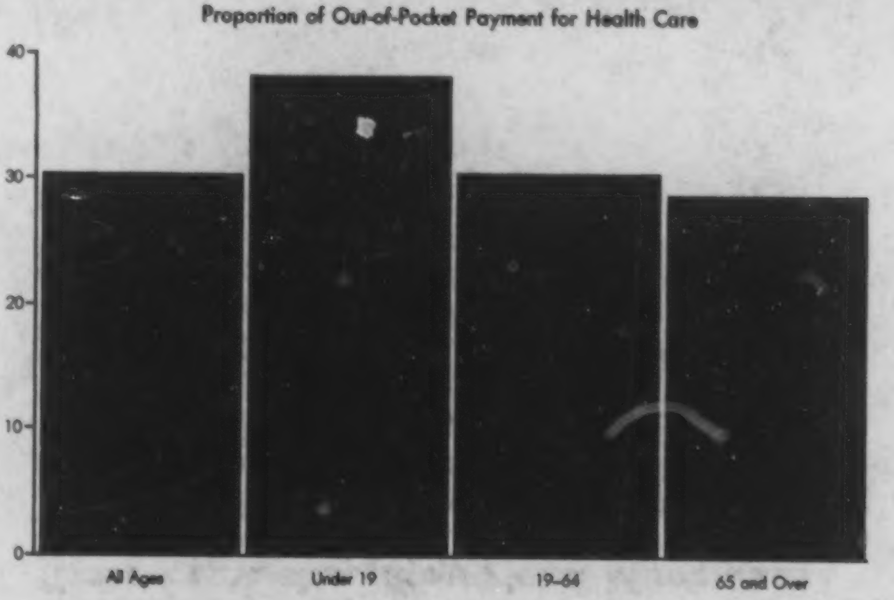
Distribution of Personal Health Care Expenditures
by Payment Source and Age Group



Source: Fisher, *Health Care Financing Review*, Spring 1980.

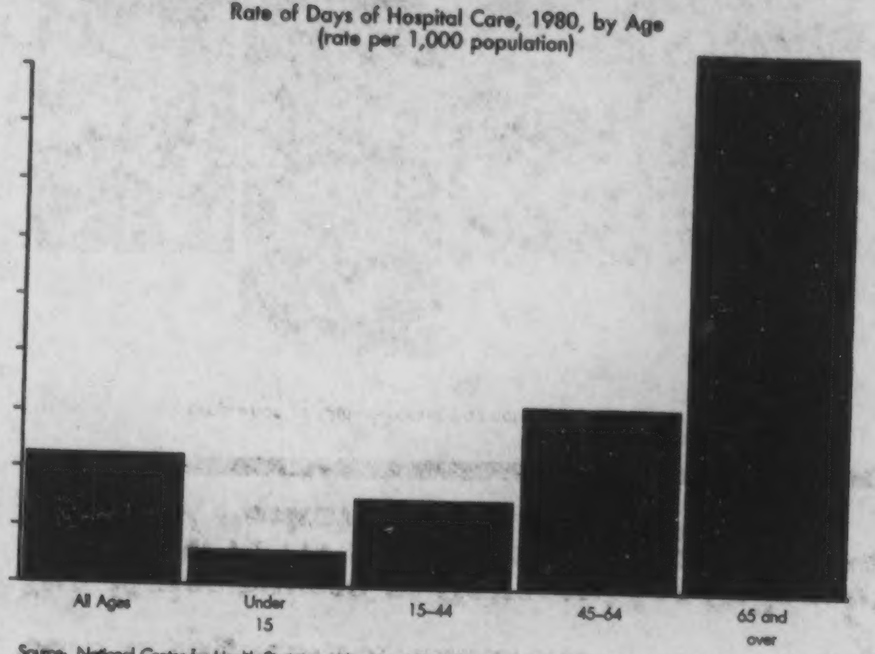
Direct/Out-of-Pocket Payment for Personal Health Care Is Highest for Children.

The Major Source of Payment for Children's Health Care is Not Private or Public Insurance, but the Families' Pocketbook.



Source: Fisher, Health Care Financing Review, Spring 1980.

Children's Health Care Needs Are Different From Those of Adults. They Need Much Less Hospitalization and Much More Ambulatory Care Than Any Other Population Group.


Rate of Days of Hospital Care, 1980, by Age
(rate per 1,000 population)

Source: National Center for Health Statistics, *Utilization of Short-Stay Hospitals: Annual Summary for the United States, 1980*, March 1982.

Current Health Insurance Policies Create Incentives for Hospitalization Which Contribute to the Escalation of Health Care Costs; at the Same Time Policies Create Disincentives to Preventive Care, Which Can Reduce Health Care Costs.

Private Health Insurance Discriminates Against Children as a Group

1. Adults have approximately 2½ times greater coverage of ambulatory care than children (whose needs for these services are proportionately greater than adults').
2. Only about 30 percent of children are covered for physician visits by private insurance. This coverage generally excludes any visits for other than acute care.
3. Private insurance pays for only approximately 9 percent of services rendered during pediatric visits.
4. Private health insurance policies seldom cover children's health care needs. For example:
    - More than 50 percent fail to cover prenatal care.
    - 45 percent exclude postnatal care.
    - 50 percent only partially cover newborns during their first days of life.

The Cost of Covering Children's Health Care Is *Minimal.*

In a recent survey of pediatricians in 14 states, the average monthly costs for covering the AAP's recommended periodicity schedule from infancy to 21, ranged from $1.79 to $3.61.

Alabama	$2.56
California	3.61
Indiana	2.85
Iowa	2.05
Kansas	2.34
Louisiana	2.31
New Hampshire	2.43
New Jersey	2.96
New York (not in city)	2.06
North Carolina	2.04
Ohio	2.20
Oklahoma	1.79
West Virginia	2.24
Vermont	2.08
(Average monthly charge	$2.32)

Total Costs for Providing All Child Health Supervision Services Required from Birth to Age 20 Costs About The Same as One Day in the Hospital.

Examples of Success in Providing Child Health Services

- Health Maintenance Organizations (HMOs) and Independent Practice Associations (IPAs) cover child health services adequately and remain profitable and have fewer hospitalizations.

- Blue Shield plans in New Hampshire, Vermont, Pennsylvania and Hawaii cover child health supervision services and are economically sound.

Preventive Child Health Care Has Measurable Favorable Effects

At least 15 studies by health care experts found that preventive child health care has a clear, positive effect on reducing health care utilization and improving children's health.

Source: Shadish, William, et al., "Effectiveness of Preventive Child Health Care." *Health Care Financing Grants and Contracts Reports.* DHHS:HCFA, April 1981.

Continuing Health Supervision Has Important Potential for Reducing Costs

1. When a physician knows the child and his/her family:
   - Some conditions which might require an office visit may be handled by telephone, and many conditions which might require hospitalization can be handled in the office;
   - Time required for medical history can be reduced when illness occurs and physical assessment can be accurate and efficient;
   - Fragmentation of services can be reduced, more efficient coordination of services allowed; duplication of medical services, procedures, x-rays, and lab tests, and unnecessary hospitalization avoided.

2. Continuing health supervision provides more than "well child" care. It provides:
   - Early diagnosis and treatment of unsuspected illness, which means that fewer ailments result in expensive hospitalization;
   - Reduced risk of complications of chronic diseases affecting many children;
   - Lowered number of office visits and charges due to telephone advice and education.

The Value of Preventive Medicine Can Be Shown Through the Examples of Immunization, Other Infectious Diseases, Orthopedics, and Vision and Hearing.

- Immunization against measles, rubella, mumps, polio, diphtheria-pertussis-tetanus (DPT) can provide primary prevention against illness, mental retardation, and even death.
- Other infectious diseases, such as hepatitis, tuberculosis, venereal disease, streptococcal disease, and bacteriological disease, if not identified and treated at an early stage, can result in further spread of the disease as well as progressive deterioration of the affected child's health.
- Identification and treatment of scoliosis and other orthopedic problems can reduce the severity of potentially serious handicapping conditions.
- Early detection of congenital visual defects, such as amblyopia, can result in reducing serious visual difficulties. When children with sensory deficits are provided with glasses, hearing aids or speech therapy, school failure and behavioral problems can be prevented.

Childhood Infectious Diseases Can Be Prevented By Immunization:

- Measles
- Mumps
- Rubella
- Polio
- Diphtheria
- Pertussis
- Tetanus

These immunizations are typically not covered by private insurance

Immunizations Have Demonstrated Their Cost-Effectiveness.

Measles: The net benefits nationally for measles immunization are estimated to be $1.3 billion for the period 1963-1972.

- Medical savings included 1.4 million hospital days and more than 12 million physician visits.
- 7,900 cases of mental retardation averted as well as premature death.
- 10,300 more persons would have the opportunity to lead productive lives measurable at 709,000 years.
- For every dollar spent on measles vaccination, $10 was saved.

Mumps:

- Of 1 million persons, mumps vaccine would prevent more than 74,000 cases of mumps and 3 deaths.
- Comparing vaccination benefits over a 30-year period with the costs of mumps (with no vaccine program) shows that the costs would be reduced by more than 86 percent — $846,827 versus $6,271,764 for each one million children, resulting in a net benefit of $5,424,937.
- For every dollar spent on mumps vaccine, $7.40 was saved.

Sources: Witte and Axnick, 1975.
Wiederman and Ambrosch, 1979.

Many Children Still Do Not Receive Vaccinations for Measles, Rubella, Mumps, Polio, and Diphtheria-Tetanus-Pertussis (DPT)

Percent of Children, 1-19, Not Immunized, 1981

Vaccine	Age Group	Percent Not Immunized
Measles	1-4	36.2
	5-6	23.3
	5-14	26.7
	5-19	33.9
Rubella	1-4	35.5
	5-6	23.2
	5-14	25.3
	5-19	31.2
Mumps	1-4	41.6
	5-6	27.0
	5-14	31.4
	5-19	42.5
Polio (3+)	1-4	40.0
	5-6	26.0
	5-14	28.2
	5-19	33.1
DPT (3+)	1-4	32.5
	5-6	23.0
	5-14	24.8
	5-19	28.4

Source: U.S. Immunization Survey, 1981

Children Provided with Early Detection of Health Problems Use Fewer Health Care Services and Are Healthier than Other Children.

1. North Dakota:	Children participating in the Early and Periodic Screening, Treatment, and Diagnosis Program (EPSDT) had 40 percent lower per capita costs and 50 percent lower hospital costs than children who were Medicaid recipients, but not participating in the program. (1975-76)
2. Missouri:	Children screened through EPSDT were on average 33 percent less costly than other Medicaid children. (1980-81)
3. Ohio:	Children screened through EPSDT have cost the state 30 percent less than those Medicaid children who did not receive a screen.
4. Southeastern Pennsylvania:	On rescreening through EPSDT, children had almost 30 percent fewer abnormalities requiring treatment, indicating the effectiveness of treatment following initial screening. (1978-80)
5. Texas:	For each dollar spent on vision screening, hearing screening, preventive dental care, and identification of congenital malformations, $8 was saved in long-term health costs and in avoiding income loss. (1975)
6. Virginia (Portsmouth):	Children provided with no care versus children provided with screening and counseling or only screening used a greater number of physician visits, prescriptions, number of hospital days and visits, costs of physician visits and prescriptions, and total health costs. (1974)

Comprehensive Care Can Result in Improved Health Status

In an experiment, a group of Baltimore children given comprehensive care suffered half the incidence of rheumatic fever compared with a control group.

Change in Incidence of Rheumatic Fever in the Study Population Eligible for Comprehensive Care Programs as Compared with Noneligible Predominantly Black Tracts and All of Baltimore

	1960–1964		1968–1970		
Population	No. of Cases	Annual Incidence (per 100,000)	No. of Cases	Annual Incidence	Net Change
Eligible	51	26.8	11	10.6	−60.4
Noneligible 90% black	15	14.0	20	17.8	+27.0
All tracts	77	20.9	42	13.5	−35.4

Source: Gordis, Leon. "Effectiveness of Comprehensive-Care Programs in Preventing Rheumatic Fever." *NEJM*. Vol. 289, No. 7, August 16, 1973.

Comprehensive Continuing Care Results in the Decreased Use of Health Care Services

During a three-year experiment, a group of children who had previously received only episodic care were then provided comprehensive care. These children had fewer hospitalizations, fewer operations, fewer illness visits and more health visits.

1. Fewer Hospitalizations

	Hospitalization for All Cases per 100 Children	
Time Period (Mo.)	Experimental Group	Control Group
0–6	4.3	2.0
7–12	3.0	3.7
13–18	1.8	3.3
19–24	1.9	3.6
25–30	3.0	3.9
31–36	3.4	3.5

2. Fewer Operations

	Operation Only per 100 Children	
Time Period (Mo.)	Experimental Group	Control Group
0–6	1.6	0.5
7–12	0.8	1.6
13–18	0.8	1.2
19–24	1.0	2.0
25–30	1.3	1.9
31–36	2.0	2.0

3. Fewer Illness Visits

	Illness Visit Rate per 100 Children	
Time Period (Mo.)	Experimental Group	Control Group
Pre-experimental	23.0	21.7
6	15.9	21.4
12	10.0	17.8
18	13.4	19.1
24	15.1	16.6
30	17.7	19.8
36	17.1	21.2

4. More Health Visits

	Health Supervision Visit Rate per 100 Children	
Time	Experimental Group	Control Group
Pre-experimental	5.2	6.2
6	12.3	4.2
12	7.3	2.1
18	8.3	6.8
24	8.0	4.0
30	8.7	5.7
36	5.3	2.9

Source: Alpert et al. "Delivery of Health Care for Children: Report of an Experiment," *Pediatrics*. Vol. 57, No. 6, June 1976.

STATEMENT OF JOHN F. TROY, JR., TRAVELERS INSURANCE, HARTFORD, CONNECTICUT, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. Troy. Thank you, Senator.

My name is John Troy. I am a vice president of the Travelers Insurance Companies. I am appearing today on behalf of the Health Insurance Association of America, and with me is Martin Dickler, who is an actuary with the Health Insurance Association of America.

The administration has asked Congress to levy a tax on employee health plans as a part of its fiscal year 1984 legislative program. In addition, the administration has already proposed that the tax be increased to finance grants to the States for health insurance for the unemployed, although insisting that the purpose of the tax is to contain rising health costs, not raise revenues.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will not be effective in containing health care costs.

We also question whether the tax will raise the revenue suggested, as labor-management negotiations rearrange the employee benefit plan.

Among our concerns with this tax is the fact that it penalizes older workers. Older groups tend to use health care more frequently than younger, healthier workers; thus, the costs of their health insurance would be higher, and the resultant tax would be higher.

For example, the premium rates for a group of employees age 55 and over are roughly three times that of an employee group averaging under age 35. A plan costing the younger group $100 a month would cost the older group $300 a month and substantially more tax.

It also would penalize those in high-risk occupations. Certain groups such as workers in the health service industries have typically higher claim costs than typical office worker groups like banks, insurance companies, or government workers, and therefore would be more susceptible to tax. To stay under the limit, the high risk groups would have to have a smaller benefit package; thus, less benefits would be available to those who are in the greatest need for health services.

The tax is a form of double taxation. Premiums go up for a number of reasons, one of which is the medicare cost shift, which we estimate transferred $7.9 billion in hospital costs from medicare to the private sector in 1983. That results in higher premiums. To then tax that higher premium is taking two bites from the same apple and seems basically unfair.

This tax would also unfairly impact certain geographic areas. An example in our white paper which we submit for the record compares a Los Angeles employee with family coverage with a similar employee in Greenville, S.C. Under the health tax at the $2,100 a year exemption level, the Los Angeles employee would have imputed income of $2,963—41 times the imputed income of $72 for the Greenville, S.C. employee.

The tax could also result in reduced coverage for preventive services. In this connection, the Rand Study on Health Care Costs published in November 1982 concluded, among other things, that people would probably not reduce their insurance coverage uniformly and that dental care, ambulatory care, drugs, and preventive services would tend to become uncovered, while hospital insurance coverage would probably be the least changed.

It stands to reason to us that since hospital coverage protects against the highest risk, it would be the last to go.

The study raises another concern. It points out that while a typical proposal for taxing employees on half of employer-paid contributions could reduce hospital use and thus hospital revenues, the hospitals could get back most of the lost revenues by raising prices.

With the passage of the social security amendments of 1983 putting medicare on the new DRG prospective payment system set by HHS, it won't be the Government hit by the new round of higher prices, it will be the private sector, including insurers and self-pay patients. The end result will be health insurance that is more expensive, people having less protection, hospital prices higher for those who need their services, with hospitals getting about the same amount of revenues to cover their overall fixed expenses.

The Rand Study concludes on another cautionary note. I quote: "Effects on consumers' health status are as yet unknown but will have a considerable effect on the desirability of such changes in public policy."

We believe that encouraging people to cut back on preventive services will have a detrimental effect on consumers' health status.

We believe the most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just medicare patients. We are beginning to see that prospective payment systems that include all payors, including medicare, which are in place in four States, can work.

Mr. Chairman, I ask that a paper on the health care tax prepared by HIAA and previously sent to the members of the committee be included in the record as well as the attached resolutions subscribed to by a number of organizations who wish to be recorded as opposed to the employee health tax.

[The information and resolutions follow:]

Whereas a tax on employee health benefit pans would be discriminatory and unfair in application and ineffective as a means of slowing the rising cost of hospital care, we urge the Congress to REJECT any tax on employee health benefits.

Health Insurance Association of America; American Dental Association; National Association of Casualty and Surety Agents; International Association of Machinists and Aerospace Workers; Caterpillar Tractor Company; Small Business Council of America, Inc.; International Brotherhood of Teamsters; Professional Insurance Agents; Society of Professional Benefit Administrators; Aetna Life and Casualty; New York Life Insurance Company; Insurance Association of Connecticut; Peoples Life Insurance Company; Alliance of American Insurers; American Council of Life Insurance; The Travelers Insurance Company; American Optometric Association; American Psychiatric Association; American Federation of Teachers/Federation of Nurses and Health Professionals; National Education Association; U.S. Chamber of Commerce; Blue Cross/Blue Shield Associations; Group Health Association of America; Laborers International Unions of North America, AFL-CIO; Health Resources Corporation of America; Family Health Program (FHP, Inc.); Association of Private Pensions and Welfare Plans; CIGNA; Transamerica Occidental Life Insurance Company; American Dental Hygienists' Association; Kemper Group; Independent Insur-

ance Agents of America; American Dental Trade Association; National Association of Private Psychiatric Hospitals; Delta Dental Plans Association; American Speech-Language-Hearing Association; National Association of Insurance Brokers; National Association of Life Underwriters; National Mental Health Association; American Hotel and Motel Association.

Federal Proposals To Tax Employees on Health Insurance Premiums Paid by Employers

The Federal Administration is proposing to tax employees on employer contributions to group health insurance plans. Advocates claim that the tax would both increase Federal revenues and help contain health care costs. But in our view, this kind of tax would fall upon taxpayers in a haphazard, unfair manner. The actual revenue generated could prove to be small, although the administrative burden on employers could be costly. As a device to contain health care costs, this tax is likely to accomplish little or nothing.

In the following pages, the tax proposal is explored as a revenue raiser and as a health care cost containment measure. Also included is a commentary on a recent study by Amy K. Taylor and Gail R. Wilensky entitled "Tax Expenditures and the Demand for Private Health Insurance."

Proposed Tax as a Revenue Raiser

The desire of the Administration to narrow the Federal budget deficit is understandable and laudable. We can also understand the initial attractiveness of employer contributions to group health insurance as a new source of taxable income. Before embarking upon such a course, however, the adverse impact of this kind of taxation on both employees and employers, and the likely amount of revenue that would be generated should be carefully considered. Let us review each of these.

Impact on Employees

Group health insurance is purchased by employers for the benefit of employees, usually with the advice of experts. The employer usually selects the coverage, except when the insurance plan is the subject of collective bargaining. Normally, the cost of the plan is either borne entirely by the employer, or largely by the employer with some employee contribution required. If the employer's cost were to become taxable income to employees, such cost would have to be allocated to each employee as imputed income, whether or not there is an exemption of some dollar amount. To be fair, each employee's imputed income should be based upon the actuarial value to him of the health insurance plan.

Essentially, this means determining annually each employee's share of the employer's cost as a function of the principal actuarial factors: age, sex, coverage for dependents and place of residence. The extent to which this can be done depends upon premium rating practices and available data, which generally differ for small and large groups.

Small groups (under 50 employees)

Let us first consider employees who work for firms with fewer than 50 employees. According to United States Department of Commerce data, there were 4.3 million firms with one to forty-nine employees in 1980. According to insurance company data, these small groups probably provide employment for over 15 million workers. There are many carriers active in the small group market and each offers a variety of health insurance plans from which an employer can choose.

A common characteristic of plans sold to small employers is that schedules of age- and sex-specific premium rates are used, which are adjusted for the geographic area in which the firm is located. Premium rates may also be adjusted to reflect the industry classification of the firm. With this kind of rate structure, there is a specific premium for each employee reflecting age, sex, dependents covered, type of industry, and locality. Such premium rates represent the actuarial value of the plan to the employee, as calculated by the insurance company, and the employer's share of the premium could be readily used as imputed income.

Table I shows the yearly imputed income for a male employee, age 40 to 44, covered by a comprehensive medical expense plan, assuming premium for that age was used for imputed income. In this example, it is assumed that the employer share of the premium is 75 percent, and the firm has two-to-nine employees. The premium rates used are an average of those in actual use as of January 1, 1983, by five carriers, in three high-cost and three low-cost cities.

It is apparent from Table I that if the employer's contribution were fully taxable, the impact on employees would vary widely from city to city, reflecting regional differences in the cost of health care. A single employee in Los Angeles would have $1,652 in imputed income compared to $714 if he were employed in Greenville, South Carolina. If the employee had dependent coverage, the corresponding imputed incomes would be $5,063 and $2,172. In each case, the Los Angeles employee would have more than twice as much imputed income as his Greenville counterpart.

If only the employer's contribution above a specified "tax cap" were to be taxable, the amount of imputed income would then also depend upon the level of exemption. Table I shows the effect of four levels of tax cap, where each is a uniform amount nationwide. If the tax cap were set at the level proposed by the Reagan Administration—$840 per year for an individual ($70 per month) and $2,100 a year for a family ($175 per month)— the amount of imputed income would decrease in all six cities. An individual in Los Angeles, in this case, would have an imputed income of $812 while his counterpart in Greenville would have no imputed income. If the Los Angeles employee had dependent coverage, his imputed income would be $2,963, which is 41 times the imputed income of $72 for the corresponding Greenville employee. The use of a nationwide uniform tax cap therefore, would result in inequity in how the tax burden would fall upon

Table 1

Yearly Imputed Income for Males Aged 40-44, Employed in a Group of 2-9 Employees

(Employer Contribution Equals 75% of Premium for Comprehensive Medical Expense Plan*)

	Exemption Amounts:				
City	None	$450 Ind. 1125 Family	$720 Ind. 1800 Family	$840 Ind. 2100 Family	$975 Ind. 2400 Family
Individual					
Los Angeles	$1652	$1202	$ 932	$ 812	$ 677
Miami	1333	883	613	493	358
New York†	1283	833	563	443	308
Fargo, ND	848	398	128	8	None
Macon, GA	839	389	119	None	None
Greenville, SC	714	264	None	None	None
Family					
Los Angeles	$5063	$3938	$3263	$2963	$2663
Miami	4122	2997	2322	2022	1722
New York†	3966	2841	2166	1866	1566
Fargo, ND	2587	1462	787	487	187
Macon, GA	2552	1427	752	452	152
Greenville, SC	2172	1047	372	72	None

*Based on average of premium rates as of January 1, 1983 of five carriers. Plan includes full maternity coverage. No extra factor for a high-risk industry.

†Manhattan

taxpayers in small local groups, by reason of their place of residence.

Table I illustrates the unfairness to employees by place of residence. A uniform tax cap that does not reflect age and sex would similarly shift more of the tax burden to older employees and females, since premiums increase with age and are higher for females than males. If a particular tax cap were to be used, it should be adjusted for age, sex, and locality to preserve the fair allocation of imputed income on the basis of actuarial value (in this case premium.)

Current proposals call for a uniform, nationwide tax cap and do not reflect age and sex. In order to have imputed income on the same basis, each employee would have to be assigned imputed income on the basis of the group's computed average premium per employee. This would, however, simply introduce a different form of inequity. Take, for example, a small group of a self-employed 55-year-old accountant and a 20-year-old secretary. Each would have inputed income equal to the average of their premiums, but the secretary would be subsidizing the accountant with respect to allocated imputed income. Speaking more generally, if each small group employee were assigned imputed income on the basis of an average premium, the young would subsidize the old and males would subsidize females. And, of course, there would still be wide difference in tax liability by area as shown in Table I.

Larger groups (50 or more employees)

Larger groups generally have at least 50 employees, and can range to hundreds of thousands. For such groups, premium rating practices are quite different from those described for small groups. Employers with insured plans typically remit monthly "billing" premiums, but the final cost depends upon actual claim experience, expenses and other factors for the policy year. For the present purpose, it will be assumed that billing premium reasonably approximates the cost of the plan.

The premium is typically a specified monthly amount for employee coverage regardless of age and sex. There are one or more additional premiums for dependent coverage, depending upon the number of separate dependent classifications. These are essentially averages that, through experience rating, incorporate the group's actuarial characteristics of age, sex, dependent composition, geographical distribution of employees, type of industry, and claim experience. Average premiums are changed annually to reflect recent claims experience, and the anticipated increases in health care costs for the coming year. This would include provision for inflated health care charges due to cutbacks in Medicare and Medicaid payments, i.e. the "cost shift" to privately insured persons.

Since the per-employee and per-dependent unit premiums are adjusted each year and remain broad averages, the actuarial value of the plan for each employee is not readily available. This presents a major problem in determining a fair allocation of employer cost for each employee. The practical approach would be to use the per-employee premium to allocate imputed income. (With a suitable adjustment when employee contributions are involved.) If this were done, however, young employees would be allocated imputed income in excess of the actuarial value of the plan to them. Older employees would be allocated less imputed income than their actuarial value, and would enjoy a subsidy. Under this system, employers might become reluctant to hire older workers. Likewise, a firm's employees living in low cost areas would subsidize their fellow employees living in high cost areas. In any given group of employees, there would be much "cross subsidy," or redistribution of imputed income for tax purposes. The use of per-employee and per-dependent unit premiums would be in sharp contrast to the fairer distribution of imputed income in small groups, where the age, sex, and area specific premiums reflect actuarial value.

If a uniform tax cap were used in conjunction with imputed income allocated on per-employee premiums, any excess of imputed income over the tax cap would be the same for all employees in the group. The imputed income "after tax cap" would still involve subsidies of the old by the young, females by males and employees in high cost areas by the firm's employees in low cost areas. Under this approach, many inequities are possible. An entire group might escape imputed income if the group's average age were low, or the bulk of the employees lived in low cost areas, or the group enjoyed better than average health. Conversely, a group with a high average age, or heavy concentration of employees in high cost areas, or worse than average health would be much more likely to be taxed. The impact on individual employees could vary sharply. For example, an employee living in Los Angeles might not have any imputed income if the rest of the firm's employees worked in Greenville, South Carolina. This would be very unfair to other Los Angeles workers employed in smaller local firms, and exposed to large taxes. Under this approach, an employee's imputed income would mainly depend upon the overall actuarial characteristics of his firm, and not at all on the actuarial value of the plan to him. This would result in a haphazard distribution of imputed income, difficult to defend or explain to employees.

The alternative to the direct use of per-employee premiums is to calculate the actuarial value of the plan for each employee. This would be a much fairer approach in theory, and would put large groups on the same basis as small groups. A major weakness in this method, however, is that the calculation of actuarial value would require many estimates and approximations, especially when the employees are widely dispersed. Most employers would not have readily available the kinds of data that would be needed. As an example of the problem, consider a firm based in a high cost city with one sales representative in a low cost city. The actuarial value for the low cost city employee, derived from a broad premium average where all other employees are in a high cost city, will of necessity be based upon theoretical considerations. Many examples could be given to illustrate the difficulty of calculating actuarial value when age, sex and area-specific premium rates are not used. The task of computing the actuarial value of the plan for each Federal employee would indeed be a challenge. And, of course, if a derived actuarial value were used for the allocation of imputed income, the use of a uniform nationwide tax cap would create the same unfair shifting of tax burden as for small groups.

We do not know how the final regulations would prescribe the allocation of an employer's cost to imputed income, or to what extent a tax cap would reflect actuarial factors. It is highly likely, however, that whatever rules are adopted, this tax burden will fall upon millions of employees in an unfair and haphazard manner. A brief summary of the possible impact on employees, depending upon the more likely methods of determining imputed income and the tax cap, is as follows:

(1) If the basis for allocating imputed income were actuarial value, for *all* groups, small groups could use the premium structure but large groups would have to make many estimates and approximations on theoretical grounds. This would be especially true of self-insured groups, where there is no "pre-

mium," and imputed income would be an allocated share of incurred claims. Despite the necessity of approximations for large groups, the use of actuarial value would be the fairest way to allocate imputed income. If, however, a uniform tax cap were used nationwide, without adjustments for age and sex, the tax burden would be unfairly shifted to employees who are older, female, and living in high cost areas.

(2) If imputed income were to be allocated for all groups using per-employee and per-dependent unit premiums, large insured groups could use their premiums. Self insured groups would have to estimate such premiums. Small groups, however, with age-and sex-specific premium rates would have to convert on some basis to a per-employee average. This would mean large fluctuations in imputed income from year to year for small groups, where the age and sex distribution could sharply change with employee turnover. As a result, the allocation of imputed income could become chaotic. The use of per-employee premiums to allocate imputed income would produce much inequity within each employee group, for groups of all sizes. Young employees would subsidize older employees and males would subsidize females. With inequities such as these, an employer may be reluctant to hire older employees or females, as the potential tax liability for all employees is increased. A large firm's employees in low cost areas would subsidize fellow employees in high cost areas.

The use of a uniform tax cap that did not vary by age and sex would preserve the many cross-subsidies built into the basis for allocating imputed income. An employee's imputed income would depend greatly on the actuarial make-up of the firm rather than the value of the plan to the employee, which is a haphazard method of taxation. Generally, groups with high average ages, or many females, or heavy concentrations of employees in high cost areas, or in poor health, would be most likely to be taxed.

(3) It is possible that because of the different premium structures in use, imputed income would not be allocated in the same manner for all groups of varying size. If actuarial value were used for small groups and per-employee premiums for large groups, there would be the same kinds of inequities and haphazardness described above, but they would be different by size of group. This would compound the problem of inequity, as imputed income and tax liability would also vary according to the size of group.

For employees changing employment, the change in tax liability could fall in an arbitrary and capricious manner.

(4) Whatever method is adopted for the allocation of imputed income, the amount allocated to each employee can fluctuate substantially each year, exposing the employee to tax liability in an unpredictable fashion. This can happen in several ways.

Group claim experience can and does fluctuate from year to year, which is reflected in premium rates, which would then be reflected in imputed income. A group may have good experience for a period of years, and nominal rate increases, and then have "bad years" of experience causing large rate increases. An employee can suddenly be exposed to an unanticipated large imputed income.

Another example of this unpredictability is when an employee changes employment from one group to another with a different age or sex distribution, different mix of employees by geographical area, or different type of industry. Depending on the methods of computation used, his imputed income may change sharply in either direction. For example, a Washington representative of a national bank could suddenly have substantially more imputed income if he or she changed employment to represent a large mining company, with no change in coverage. Similarly, if a representative of a Macon, Georgia firm changed to represent a Los Angeles firm, imputed income would also increase.

Overall, many problems exist in allocating imputed income and in structuring the tax cap. They are such that inevitably many employees will either be lightly taxed or not at all, at the expense of others who will carry a disproportionate share of the burden. Employees will often be exposed to the tax in a haphazard and unpredictable manner, especially upon changing employment, and will likely find explanations difficult to understand or accept.

Impact on Employers

The imposition of a tax on employer contributions to a group health insurance plan will increase the employer's administrative costs. This will reduce Federal revenue from corporate income taxes to the extent that corporate profits are reduced, or increase the costs of goods and services to consumers. The following considerations illustrate the likely impact on employers.

(1) The vast majority of workers have group health insurance, and although a tax cap may exempt

many from paying tax, an employer must be prepared to establish appropriate records for all employees under the group plan. A key expense consideration will be the process by which the employer's cost is allocated to each employee. The more equitable the allocation of imputed income is to employees, the more expensive it is likely to be to administer.

(2) Large employers can have many health insurance plans in effect, but there is usually not more than one at a given location or for a specific bargaining unit. All such plans may not have been rated separately in the past, but now each would have to be separately treated for imputed income purposes. It is not uncommon for a large employer to have dozens or a hundred or more health insurance plans in effect, reflecting collective bargaining activity with many unions. The need to treat a multitude of plans separately for imputed income purposes will increase administrative costs for both large employers and insurance carriers.

(3) Group health insurance premiums are normally changed once yearly, but the annual effective date of change can be at any time in a calendar year. The rate change date might be the anniversary of the group policy, or the employer's fiscal year, or any other date that is mutually agreed upon. Since imputed income to employees must be based on a calendar year, many employers will have to cope with *two* sets of premium rates in each calendar year, thus driving up the costs.

(4) Special adjustments will be necessary for employees who add or drop dependent coverage during the year. Special calculations will be required for newly hired and terminating employees. Expensive changes to electronic data processing systems may be required.

(5) The new imputed income will increase all employers' social security taxes. This may be especially difficult for the small employer, who will also be pressed by higher bookkeeping costs.

(6) Special accounting problems may arise in relating an employer's billing premium to true cost determined after the end of a policy year. To the extent that the employer's true cost is less than premiums, through dividends or other credits, the imputed income to employees should also be reduced, perhaps retroactively. This could entail more complications in accounting and recordkeeping for the employer.

It is ironic that an Administration committed to less regulation and Federal reporting requirements should be proposing a tax change that would add extensive new employer administrative duties.

Amount of Revenue Likely To Be Raised

The amount of an employee's imputed income subject to tax will depend upon how imputed income and the tax cap are calculated and applied. Until these matters are decided, the way that the tax burden will be distributed by age, sex, family status, place of residence and size of group is unknown. It is very likely, however, that once the rules are set many employers will explore the opportunities for legitimate tax avoidance. The incentives are to minimize administrative problems and to spare employees from an inequitable and haphazard tax burden. In addition, union leaders will seek methods to avoid the tax on behalf of their membership.

The general thrust of these "tax avoidance" arrangements will be to reduce employer contributions to the group health insurance policy to eliminate tax liability, and to shift an equivalent amount into benefits which are either completely tax free or at most tax deferred for many years. An example of the former is increased vacation allowance, while examples of tax deferred benefits are pension plans and company contributions to savings programs. The particular approach would depend on the amount of contribution to be shifted and other factors such as the distribution of tax liability. Although an employee's contribution to his or her health insurance plan would increase, the tax would have been avoided. The increased tax free or tax deferred benefits will leave the employee in about the same position as before the tax was imposed. Both large and small groups could implement tax avoidance arrangements, with the aid of in-house expertise or through consulting firms.

Although it is difficult to forecast the extent to which employers and unions will alter their plans to avoid the tax, it is likely that many will. A tax that falls in an inequitable and haphazard fashion will be difficult for employees to understand and accept. An employer who can offset an unpopular tax is likely to do so. The result will be that much less tax revenue will be realized by the treasury. Even if employers only shift contributions to tax deferred benefits, it could be many years before the treasury realizes any significant tax revenue.

Proposed Tax as a Measure To Contain Costs

The rapid acceleration of health care costs in recent years has focused attention on the need for improved cost containment. A current theory is that more effective cost containment would result if there were more competitive marketplace forces at work in the health care industry. This marketplace approach is proposed as an alternative to increased government regulation, and includes two popular concepts. One is to encourage the growth of insurance plans with reduced benefits and increased employee cost sharing. The result of cost sharing is expected to be less demand for health services and lower prices because of greater consumer cost sensitivity. This, in turn, is expected to stimulate competitive reactions from providers and ultimately result in cost containment for all patients. The second concept is through competitive alternative health care delivery systems, such as HMOs. The HMO strategy has actually been in place for several years, while the attention given to the cost sharing strategy has increased only recently.

The present lack of marketplace competition is attributed in large part to the tax free status of employer contributions to health insurance. This is said to have encouraged employees to seek "excessive" amounts of insurance, thus insulating them from significant out-of-pocket expenses and making them insensitive to health care costs. The proposed tax is expected to motivate employees to change to lower premium plans with more cost sharing features. Greater cost sharing, as noted, is expected to lead to cost containment.

The need for improved controls on health care costs is not in dispute. The justification of the proposed tax as a cost containment measure, however, rests upon (1) a theory that significant numbers of employees will shift to plans with more cost sharing, and (2) a theory that more cost sharing will actually result in more cost containment for all patients. It is important to consider the plausibility of these theories before complex tax legislation with many adverse results is enacted in the name of cost containment.

Let us first consider the likelihood that a significant number of employees will become covered under plans with more cost sharing. The actual number of employees affected by the tax will depend upon the methods of calculating imputed income and the tax cap, and the prevalence of tax avoidance arrangements. It is clear, however, that for those employees who do become liable, the tax would represent an increase in the cost of their insurance. A decision to seek less insurance will vary greatly with the employee's circumstances. These would include the amount of tax involved, a family member's health status, the nature of the reduced benefits in the lower premium plan, and the employee's degree of aversion to the financial risk of medical expenses.

The relative ease with which the employee could change to a lower premium plan is also of importance. In this regard, there are two situations to consider. The first is where a single group health plan is to apply without any choice of insurance plans available. The second is where there would be a legal requirement for an emloyer to offer at least two conventional insurance plans with different benefit levels. It is important to explore the impact of each situation:

(A) Employer maintains a single conventional insurance plan but includes HMO options when available.

Employers typically offer either a single company-wide insurance plan, or a single plan for all employees at a given location or in a specific bargaining unit. Since the HMO Act of 1973, qualified HMO options have been increasingly offered where available.

If the tax motivates some employees to desire a lower premium plan, they must secure the employer's agreement to change the plan for all employees. If the plan is under collective bargaining, union agreement would be needed as well. Before agreeing to a plan change for all employees, the employer must be convinced that most employees would willingly accept a plan with a higher deductible or coinsurance or which covered fewer expenses. For most groups, such a change is unlikely.

Most people tend to be "risk averse" with regard to health care. The preference for high level health insurance protection reflects a desire to be relieved of financial risk and emotional pressure upon the occurence of accident or sickness. It is doubtful that any significant proportion of employees will seek more out-of-pocket exposure to hospital and medical expense, or wish to have fewer services covered.

When people who do not have access to group coverage buy individual health insurance policies from insurance companies, the strong preference is for first dollar hospital and surgical plans. In 1981, the largest number of such persons, 12.7 million, were covered under basic hospital and surgical policies. Federal employees have available a choice of insurance plans, as well as a choice of alternate plans (HMOs) in many areas. It has been observed that the plans with the highest level of benefits are by far the most popular in terms of enrollment. It has also been noted that medicare supplement insurance is widespread among persons covered by Medicare. In 1981, over 15 million persons age 65 and over had private hospital insurance protection and over 11 million had private surgical expense coverage. It is evident that the bulk of senior citizens tend to be risk averse.

The next most popular category was Comprehensive Major Medical, which covers both hospital and surgical out-of-hospital expenses. There were 3.7 million covered under this type of policy.

The least popular type of policy was Supplementary Major Medical, under which only 2.7 million were covered. This policy involves large deductibles ($500 to $2,500 and up) and is designed both for people with other base plan coverage and for those without other coverage who self-insure the large deductible amount.

Sales of these individual policies are to people who are spending after-tax income, and who have a broad selection of plans and carriers from which to choose. It seems that such people are strongly risk averse when it comes to hospital and surgical expense, and favor first dollar coverage.

It would be logical to expect that group-insured persons would also be risk averse, despite the presence of a new tax. This is especially so since the tax, or additional employee "price," will normally be much less than what non-group insured persons pay for individual policies. There is little reason to believe, therefore, that any significant number of employees will seek less insurance as a result of the tax on employer contributions. Those who do are likely to be attracted only to plans that preserve hospital and surgical coverage at the expense of vision, dental and other ambulatory care benefits.

In addition, an employer is not likely to change to a lower premium plan to satisfy a minority of employees. If collective bargaining is involved, the union leadership would face the same dilemma. A plan with more cost sharing might well be resented by employees who either are not liable for tax or who are being subsidized by other employees by the way the rules are written.

It seems more likely that employers would adopt a tax avoidance arrangement than change to a lower premium plan. This might avoid a plan change that would displease most employees, would solve the employee tax problem, and would avoid the administrative problems of the tax. The financial impact on the employer would be the same whether or not a change to a lower premium plan occurred. This is because under either approach the employer would reduce his contribution to the tax cap and pass the full reduction to employees in additional tax free or tax deferred benefits. Thus, whether or not many plans are changed, the treasury is not likely to realize much current revenue from this tax.

Overall, the risk averse nature of people and the difficult employee relations problems faced by employers are such that few groups are likely to change to lower premium insurance plans. From the HMO viewpoint, this should be a welcome development, since HMOs, with relatively higher premiums would have more difficulty competing against a company plan with more cost sharing.

(B) Employer offers a choice of two insurance plans as well as HMO options where available.

The legislation imposing the tax on employer contributions may also require employers to offer two insurance plans, one costing less than the other. The employer would probably be required to make the same contribution to each plan, and provide a rebate to an employee if the premium for his plan were less than the employer's contribution. Under this approach, any employee motivated by the tax to seek a lower premium plan could do so directly. This avoids the problems in changing a single plan that applies to all employees, and could result in more employees becoming covered under plans with more cost sharing features. The choice of plan process, itself, however, will produce severe distortions between the cost of the insurance plans, which will eventually make employee choice meaningless.

The risk averse nature of people described previously will initially limit the number of employees changing to lower premium plans, especially if significant cost sharing of hospital and surgical expense is involved. Those who do change, however, will be less likely as a class to need medical care in the near future than those who remain in the higher premium plan. This is because some of the employees who might be attracted to the lower premium plan will not change if future medical expenses are anticipated, which is known as adverse selection.

Adverse selection when a choice of plans is available, is a natural consequence of the tendency of employees to act in their own best interests when making their decisions. The degree to which it occurs depends upon the benefit differences of the two plans. Employees that anticipate large inpatient expenses for elective surgery in the near future will avoid a plan that requires more cost sharing of hospital and surgical expense. Employees with chronic illnesses, requiring frequent physician office visits and prescription drugs will avoid a plan with little or no out-of-hospital coverage. It is difficult to control adverse selection without severely limiting in various ways the employee's freedom to choose.

The subsequent effect of adverse selection will be a major distortion in the premiums required for the two insurance plans. At each annual opportunity to change plans, the rearrangement of employees by their medical needs will become more pronounced. The cost of the higher premium plan will increase much more rapidly than will the cost of the lower premium plan, which will force a revision in the way the employer's contribution is computed. If the contribution were linked to the high premium plan, the employer would soon be faced with much higher *total* contributions. This would be due to the rapidly increasing high premium plan costs, and the requirement to provide rebates to those in the lower premium plan. In order to control his cost, the employer would be likely to set his contribution each year in a manner unrelated to the specific premium for any plan. This would force larger and larger employ*ee* contributions under the high benefit plan, as the premium rose faster than the employer contribution.

As a result, even employees who would naturally desire the higher premium plan may feel compelled by high employee contributions to change to the lower premium plan. This could be disastrous for financially pressed lower paid employees who select the low premium plan, and then suffer the expenses of a major illness or accident. It is also a disaster for less healthy employees in the high premium plan, who pay ever increasing contributions for their coverage. The distortions produced in premium and employee contributions are such that employees will be less and less able to make rational choices with respect to price. The financial problems and employee discontent engendered would eventually either force a return to a single plan, or a narrowing of the difference in benefits between the two plans, or a cross-subsidization of the two plans' premium. The smaller the group involved, the faster the breakdown.

The requirement to offer two insurance plans would also mean much additional administrative expense for employers. The complications of permitting annual changes and providing rebates will drive up record keeping and electronic data processing expense. Many employers are likely to attempt to minimize this situation through tax avoidance arrangements. The effect on HMOs could be dramatic if employees could easily change to a low premium plan and even receive a rebate.

HMO premiums are normally in the range of high benefit plan premiums, so that HMOs would likely lose enrollment and suffer from adverse selection. Thus, the encouragement of the cost sharing strategy through employee choice could work against the HMO strategy for cost containment.

Overall, the tax together with a choice of plan requirement might temporarily result in more employees changing to low cost plans. Through the effects of adverse selection, however, the choice of plan structure would either be abandoned or the plan differences would be narrowed. Another solution might be to cross subsidize the two plans, but all of these outcomes are contrary to the original purpose of the two plans. The end result will be a few employees covered under low premium plans. The added burdens on employers will make tax avoidance arrangements even more attractive.

It was noted earlier that the link between the tax and better cost containment rests upon two theories. The first is that the tax will lead to a significant number of employees becoming insured under lower premium plans with more cost sharing. We have seen that this is not likely to result whether employers have a single plan or provide for employee choice. The second theory is that greater cost sharing will actually result in more cost containment for all patients. Let us consider the likelihood that this will occur.

Persons covered under plans with more cost sharing are expected, through their heightened cost sensitivity, to become more astute buyers of health care services. The average consumer, however, is not equipped to judge whether prescribed medical services are needed, or to shop hospitals and physicians for price value. Furthermore, most often the consumer would lack the emotional composure required to reach an informed decision. These are some of the reasons for the widespread consumer acceptance of comprehensive health insurance. When persons subject to more cost sharing avoid medical care, there may be longer range impacts on health status that are not presently well understood. More evidence needs to be accumulated to support the view that cost aware consumers can fulfill a marketplace role, without impairing their health in the process.

Under the theory, cost containment will be improved for all patients when hospitals and physicians respond to marketplace pressures and become more efficient and competitive. The marketplace pressures are to be produced by the persons covered under plans with greater cost sharing, who will utilize fewer services. Since, however, these persons are expected to be few in number, providers can simply increase fees. Most patients will remain covered by comprehensive insurance, and it will not be difficult to compensate for any income losses from patients with greater cost sharing plans. In addition, persons with more cost sharing on out-of-hospital benefits may seek hospital admission in order to have diagnostic tests covered. This could drive inpatient costs even higher. As long as these reactions are possible, the objective of cost containment through more cost sharing plans is not likely to be achieved. Competition between the traditional fee-for-service system and prepaid organizations such as HMOs may serve to control costs. A minority of persons with less insurance coverage, however, is not likely to induce much provider competition or cost containment.

In summary, the two theories underpinning the justification of the tax as a cost containment measure are not very plausible. Significant numbers of employees will probably not change to plans with more cost sharing. Those who do are not likely to produce the marketplace reactions from providers that will lend to cost containment for all patients. The impact of the tax on cost containment, therefore, is expected to be negligible, and possibly detrimental to the HMO strategy for cost containment.

Review of "Tax Expenditures and the Demand for Private Health Insurance" by Taylor and Wilensky

A recent paper on taxing employers' contributions to group health insurance is entitled "Tax Expenditures and the Demand for Private Health Insurance" by Amy K. Taylor and Gail R. Wilensky. This paper provides estimates of the revenue to be gained by the federal and state governments. In addition, estimates are made of an anticipated reduction in health insurance premium. This is expected to occur as the tax motivates employees to seek reduced insurance, which, in turn, is to lead to better cost containment.

The authors identify the cost containment aspect of the tax as being of more importance than the revenue to be raised. The focus of the paper is on the expected changes in health insurance premiums. More public attention has been given, however, to the estimated amounts of revenue than the cost containment issue. The projections of revenue and reduced premium are based on several key assumptions, some of which are stated, while others are not mentioned. Since the assumptions are weak in various respects, the projections should be placed in proper perspective.

Revenue Effects of the Tax

The authors have used an estimate of $100.6 billion of group insurance premiums for 1983, of which $77 billion is attributed to employer contributions. These figures were obtained by a projection of data gathered in a 1977 National Medical Care Expenditure Survey. In view of the current and anticipated federal budget deficits, a new tax base of $77 billion must be considered attractive. If it all materialized as taxable income, the total increase in federal income tax is projected by the authors to be $20.443 billion. Additional revenues would also accrue to Social Security and to state governments through increased state income taxes.

It is assumed in the paper that the projected tax revenues would be the same regardless of the extent to which employees may change to lower premium plans. This is because if an employee changes to a lower premium plan, his or her other *taxable* compensation is expected to be increased to the extent that the employer's contribution is reduced. There is a second assumption mentioned at the end of the paper, the validity of which is essential if the revenue projections are to have any meaning whatever. This assumption is to the effect that employers and unions will *not* adopt tax avoidance arrangements, regardless of whether any plan changes occur at all. In our view, this assumption is difficult to justify.

The task of distributing $77 billion of employer contributions to employees as imputed income will be extremely complex. It is virtually certain that the distribution will be inequitable by age, sex, and area of the country. Frequently, the tax will fall in haphazard and unpredictable ways. Tax avoidance arrangements could easily become common occurrences, under which sufficient employer contributions would be diverted into other tax free or tax deferred benefits, this relieving the employee's tax burden. It is clear that to the extent this occurs, the revenue projections in the paper could represent enormous overstatements in terms of current increased revenue.

In their study, the authors considered three levels of exemption, ranging from $1,125 to $2,400 per family. If the exemption amount were $1,800 per family and $720 per single individual, the total federal income tax increase expected in 1983 would be $3.454 billion, in the absence of any avoidance arrangements. Since the assumption that there will not be any such arrangements is unrealistic, the $3.454 billion estimate is likely to be grossly overstated. If three-quarters of employees become exempt, the increase in federal income tax would drop from $3.454 billion to $864 million. Most recently, a possible exemption of $2,100 per family and $840 per individual has been discussed. This would reduce expected revenue even further, and probably produce no more than $600 to $700 million in 1983 under the same assumptions.

Cost Containment Aspects of the Tax

The authors appear to support the notion that tax free employer contributions have led employees to purchase more insurance than they would have, if they were using taxable income. The increased insurance levels are thought to have contributed to the rate of inflation in the health care sector. The theory is that the tax will lead to lower premium insurance plans with more employee cost sharing, and eventually more cost containment through marketplace competition. The paper deals only with projections of expected insurance premium reductions as a result of the tax. There is no discussion of whether greater cost sharing will actually result in cost containment for all patients, which is a theory many find implausible.

The question as to whether the proposed tax will result in a shift to less insurance is of great interest. An affirmative answer is essential if the tax is to be justified as step one in the quest for cost containment. The authors have calculated the expected reductions using an equation from economic theory, relating health insurance premium, employee income and the "price" to an employee for group insurance. In this context, the proposed tax will raise the "price" of group insurance for employees who are liable for any tax.

If there were no tax exemption amount, the authors predict that the tax would produce an aggregate reduction of $7.5 billion from the 1983 premium estimate of $101.6 billion. On a long range basis, the reduction is expected to grow to $16.7 billion. If various amounts of employer contribution remain tax free, the predicted reductions in premium are less. In the near term, a reduction of $3.6 billion would result if the exemption amounts were $1,800 family and $720 individual.

There is no discussion in the paper as to what proportion of employees would have the opportunity to change to a lower premium plan. Most employers provide only one plan of insurance to all employees, either company wide or at a specific location or bargaining unit. With the risk averse nature of people, few employees are expected to desire a change, and most employers will not change a plan for all to please a small minority. It may be that authors assumed that all employers would offer a choice of a high and low premium insurance plan. This would permit more employees to change initially. The adverse selection process, however, would so distort price that eventually the choice of plan approach would have to be either drastically modified or abandoned. The question of whether many single group plans will be changed, or whether there is a viable process for plan choice, must be addressed. Without evidence that a workable process for changing plans exist, we must be skeptical that the mathematical model is of value in predicting premium reductions.

It is well known that people tend to be risk averse when it comes to the financial hazard of accident and sickness, but how or whether this was taken into account by the authors is not clear. The equations seem only to consider premiums, employee income, and the employee's price of the plan. It would seem that the degree of benefit plan reduction would be of importance when forecasting reduced amount of premium. Some insight into the reasonableness of the forecasts may be gained by an inverse process.

In Table 3 of the paper, the short term reduction in premium is estimated at $3.6 billion when the tax exemption is $1,800 per family and $720 per individual. If we assume that 10% of employees make a change, the figure of $3.6 billion suggests that on the average, the lower premium plans represented a 36.0% premium reduction. A premium reduction of this magnitude would involve substantial benefit reductions, and it is arguable whether 10% of employees would make such a drastic change.

If it is assumed that 25% of employees make a change, the figure of $3.6 billion suggests that the average lower premium plan represented a 14.3% premium reduction. This premium reduction would involve less benefit reduction, but the attractiveness of the plan would depend on which benefits were reduced and to what extent. People tend to preserve a high level of hospital and surgical coverage, so that the reduced plan benefit design would be an important consideration. The average federal tax increase at this exemption level is estimated at only $147, and it may be questioned whether as many as 25% of employees would be willing to cut benefits 14.3%.

Since the projected premium reductions seem unrelated to the process of plan change, or the relationship between benefit design, premium reduction, and consumer attitudes toward risk, they are of limited value. There may be plausible internal consistency, in the projected reductions, but more analysis should be performed to establish the reasonableness of the results.

Mr. TROY. We thank you for allowing us to be heard, and we stand ready to provide you with any information the Committee might want.

Senator WALLOP. Thank you, Mr. Troy.

[The prepared statement of John Troy follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA PRESENTED BY JOHN F. TROY

My name is John F. Troy, Vice President of the Travelers Insurance Company. I am accompanied by J. Martin Dickler, Actuary for the Health Insurance Association of America. the HIAA is a trade association of approximately 320 companies which together write over 85 percent of the country's commercial health insurance. We appear today on their behalf.

Mr. Chairman, the Administration has asked Congress to levy a tax on employee health plans as part of its fiscal year 1984 legislative program.

The Administration has further proposed, in testimony to the Senate Finance Committee on April 27, that the employee health tax, not yet enacted, be increased to finance grants to the states for health insurance for the unemployed, although insisting that the purpose of the tax is to contain rising health care costs, not raise revenue.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health-care-cost inflation, nor will it raise the revenue suggested as labor-management negotiations rearrange the employee benefit package.

Among the arguments against such a tax are the following:

IT PENALIZES OLDER WORKERS

Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration proposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.

IT PENALIZES THOSE IN HAZARDOUS, HIGH-RISK OCCUPATIONS

Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurance premiums. These groups could be unfairly taxed while other groups with similar coverage—such as clerical workers—would be unaffected.

IT IS A FORM OF "DOUBLE TAXATION"

The Health Insurance Association of America estimates that Medicare and Medicaid payment practices resulted in $7.9 billion being shifted to patients covered by private health insurance in 1983 to make up for government underpayment to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

IT UNFAIRLY AFFECTS CERTAIN GEOGRAPHIC AREAS

The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

IT COULD RESULT IN REDUCED COVERAGE FOR PREVENTIVE CARE SERVICES

As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services may be dropped from benefit plans. Dropping these benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment—the employers, the unions, the insurers—in essence, all of those in the private sector on the paying side of the equation—say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment. Those who have the most to gain by its failure to work, i.e., the health providers, say it will work to de-escalate hospital inflation. However, it is a fact that what the medical expense people fear most is hospital expense, and it is hospitalization insurance that will be the last, and least, effected by this proposal.

On this point, Mr. Chairman, I would like to call attention to the Rand study on health care costs published in November 1982, a study often referred to by the health tax proponents as demonstrating the efficacy of the health tax in reducing health costs, a conclusion to which we obviously take exception.

The study states, in any event, that while the increased cost of employee health insurance resulting from the tax would reduce the over-all amount of health protection available:

"In fact, people would probably not reduce their insurance coverage uniformly but would follow some simple principles in making selective reductions. Just as insurance was historically first chosen to cover the highest risk services (e.g., hospitaliaztion) and only later extended to cover lower risk services (e.g., physician office visits, dental care, psychiatric visits), retrenchment in coverage would probably follow similar patterns. Dental care, ambulatory care, drugs, and similar services would probably become uncovered or, at least, covered only with very large yearly deductibles of perhaps $500 or more, rather than currently typical deductibles of $150 to $200. In terms of effects on aggregate medical care market demand, most purchases of these services would be uninsured. Hospital insurance coverage would probably be least changed, because the financial risks are greatest for hospitalization."

The study raises another concern. It points out that while a "typical proposal" for taxing employees on half of employer-paid contribution could reduce hospital use by $7.6 billion, the hospitals could recover more than $5 billion "by raising prices charged the remaining patients, the government, and insurers."

Well, with the passage of the Social Security Amendments of 1983 putting Medicare on the new DRG-prospective basis, set by HHS, it won't be the government hit by the new round of higher prices—it will be the rest of us.

The end result will be health insurance that is more expensive, people having less protection, hospital prices higher for those that need their services, and hospitals getting the same amount of revenue to cover their over-all fixed operating expenses.

In essence, as a hospital cost containment device, the employee health tax is a meat-axe that misses its mark.

The same study concludes on another cautionary note, "Effects on consumers' health status are as yet unknown but will have considerable effect on the desirability of such changes in public policy."

We believe that encouraging people to cut back on preventive services will have a detrimental effect on consumers' health status.

The most sensible approach to keeping hospital costs under control is prospective pricing reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, include Medicare, now in place in four states, can work. These is no reason why the Congress should try the untested theory of taxing health insurance premiums—and every reason why it should not.

Mr. Chairman, HIAA and its member companies share this Committee's concern over rising health costs.

We believe this Committee and the Congress are to be highly commended for the passage of H.R. 1900, the Social Security Amendments of 1983.

The recently enacted law changes Medicare's hospital payment from the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the new prospective pricing system applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

The change in payment basis under Medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, health insurance premiums are increasing annually at rates which range from 20 to 40 percent depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Cost shifting totalled $5.8 billion in 1982 and will rise to $7.9 billion in 1983. As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Those who are insured face higher premiums. Those who are not—such as laid-off workers who have lost their insurance—are faced with a ruinous hidden tax exacted at a time when they are least able to pay—a tax on their already sky-rocketing hospital charges. Without government action on an all-payer system, all private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavorial changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We support federal legislation that effectively protects private patients from additional cost shifts. Such protection could take the form of a residual prospective payment system for all-payers. While such a system would provide cost containment incentives, it need not produce savings to the private sector in the short-run. Furthermore, an all-payer system would not necessarily require that all-payers initially pay the same price for each DRG. But discounts ought to be justified by savings to the hospital and be available to all patients. For example, discounts for prompt payment would be appropriate. Government patients in Maryland are an exception to this principle. While sharing in all costs to the hospital including uncompensated care, they receive an additional discount in order to stay within the aggregate federal cap required under the Medicare waiver.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from limiting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90 percent of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon find their solvency threatended as bad debts mounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans and the Rochester-employer coalition so dominate their local areas as to be successful in obtaining such volume discounts.

For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the Prudential, which is the single largest private health insurer in the country, has only 4 percent of the private health insurance market, and that is spread over 50 states. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems clearly demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change—providers, employers, unions and insurers—actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

The federal government's past role as a catalyst has helped encourage variety and innovation. We believe this is the prime role for the federal government, and should be continued. We applaud and commend the Congress for its recognition of qualified state programs as an alternative method of Medicare payment under the Social Security Amendments of 1983. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a Medicaid regard for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem—health cost inflation.

It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into Medicaid and other public assistance programs by health care inflation. Such a proposal need not, in fact, should not, require the States to set-up hospital rate-setting commissions. It need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

We further urge the Congress to take the next step on prospective pricing—to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We also recognize that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this problem so intractable.

Mr. Chairman, the health insurance business shares your strong commitment to cost containment. There is more we would like to do ourselves. Nevertheless, we find that we must struggle under some formidable handicaps. The field on which we complete is strewn with regulatory and economic obstacles that significantly interfere both with our ability to serve our customers and with efforts to improve the efficiency of the health care financing and delivery system as a whole.

Put another way, what would the insurance industry like to do and what are the barriers to their doing it?

Let us first identify these handicaps, all of which are externally imposed upon us. Then we will return to a discussion of each of them. Unlike the noninsured plans with which we compete, we are subject to stringent state regulation. Our product design creativity is also stifled by a range of provider protection laws. Unlike our chief competitors in many instances, we pay state premium taxes and federal income taxes on the earnings on our reserves. In addition, the highly competitive nature of our business and the antitrust laws preclude us from collaborating effectively for cost containment purposes.

If the efficiency of our health care system is ever going to be improved through more meaningful patient participation, we must first make certain that the choices available to consumers are not economically biased because of governmental constraints. When individuals or employers choose a third party payment mechanism, the choice should be among realistic alternatives. This is not fully possible today.

We find that many individuals and employers are increasingly frustrated when they realize that a large and growing portion of their health care expenses is paying not for their own care—over which they have at least some control—but for care given to public patients. We estimate that 16 percent of the hospital expenses incured by our policyholders is being paid for care rendered to Medicare and Medicaid patients.

This cost shift would severely impede the ability of private payors to compete with government programs under Medicare voucher system such as that proposed by the Administration.

We want Medicare to pay on the same basis as other payors. The provision in the recently-enacted Social Security Amendments providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules. Insurance laws and regulations serve a beneficial purpose in protecting the insured public. However, ERISA now precludes the states from regulating the affairs of noninsured health plans, but at the same time the federal government has failed to regulate these health plans.

The very fact that these plans are unregulated makes them increasingly attractive funding alternatives for employers. Indeed, as much as 50 percent of the new health-related business written by major insurers is no longer conventional health insurance. This is an obstacle to competition that we are not able to overcome without Congressional support.

It is also a very real impediment to innovative plan design by insurers.

We recommend that Congress require that state taxation and regulation apply equally to all funding mechanisms. We are not proposing a substitution of federal for state regulation. However, our business does support, for example, Section 3605(a)(ii)(I) of S. 1541 (the Retirement Income Incentives and Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any program losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in these state programs. Thus, self-insured plans are effectively shielded from the economic burden of the guaranteed availability programs, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The program could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility or by otherwise requiring self-insured employers to participate in such programs.

In a smilar vein, there are any number of state laws enacted to protect the interests of different classes of providers. These laws often operate to prevent the establishment of preferred provider plans by insurers and stand in the way of negotiations between insurers and providers. They essentially preclude any insurer from restricting in any way any beneficiary's "freedom to choose" any health provider the insured wishes. An interesting experiment is beginning on this subject in California; and we should know before too long whether competition among providers will be enhanced by California's new law allowing an insurer to negotiate with providers. Note, the California law still does not allow more than one insurer to jointly negotiate.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating with health providers, the development of physician profiles and patterns of care, and other such activities. Specifically:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together to assemble data.

2. Insurers should also be empowered collectively to negotiate with health care providers to develop utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

In conclusion, Mr. Chairman, we believe the rising cost of health care, particularly hospitalization, must be controlled for all Americans.

And we want to be part of the solution, not part of the problem. We have suggested some constructive things which we think would help—but taxing employee health plans is not one of them.

Taxing employee health insurance to control rising hospital costs is worse than prescribing aspirin for cancer. Not only won't it make the patient better, it may actually make things worse—in addition to the harm that comes from delaying effective treatment.

Mr. Chairman, I ask that a paper on the health care tax prepared by the HIAA and previously sent to members of this committee be included in the record at this point, as well as the attached resolution subscribed to by a number of organizations who wish to be recorded as opposed to the employee health tax.

Thank you for allowing us to be heard. You may be sure we will continue to work with the committee and its staff to solve these difficult problems.

Whereas a tax on employee health benefit plans would be discriminatory and unfair in application and ineffective as a means of slowing the rising cost of hospital care, we urge the Congress to REJECT any tax on employee health benefits.

Health Insurance Association of America; American Dental Association; National Association of Casualty and Surety Agents; International Association of Machinists and Aerospace Workers; Caterpillar Tractor Company; Small Business Council of America, Inc.; International Brotherhood of Teamsters; Professional Insurance Agents; Society of Professional Benefit Administrators; Aetna Life and Casualty; New York Life Insurance Company; Insurance Association of Connecticut; Peoples Life Insurance Company; Alliance of American Insurers; American Council of Life Insurance; The Travelers Insurance Company; American Optometric Association; American Psychiatric Association; American Federation of Teachers/Federation of Nurses and Health Professionals: National Education Association; U.S. Chamber of Commerce; Blue Cross/Blue Shield Associations; Group Health Association of America; Laborers International Unions of North America, AFL–CIO; Health Resources Corporation of America; Family Health Program (FHP, Inc.); Association of Private Pensions and Welfare Plans; CIGNA; Transamerica Occidental Life Insurance Company; American Dental Hygienists' Association; Kemper Group; Independent Insurance Agents of America; American Dental Trade Association; National Association of Private Psychiatric Hospitals; Delta Dental Plans Association; American Speech-Language-Hearing Association; National Association of Insurance Brokers; National Association of Life Underwriters; and National Mental Health Association.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, D.C.

Mr. TRESNOWSKI. Thank you, Mr. Chairman, Senator Packwood.

I am Bernard Tresnowski, president of the Blue Cross and Blue Shield Association. Our full statement has been submitted for the record, and I will briefly summarize.

We do not believe that the administration's current proposal is a well-conceived reform of the health care system. We consider the tax cap to be poor public policy either as a cost-containment strategy, as a device for generating Federal revenues, or as a reform of the tax system.

We particularly believe that a tax cap would have an adverse effect on older, disabled, and chronically ill workers.

In response to a tax cap, employers might take actions that would mean higher out-of-pocket costs for these persons because their higher illness rates result in more frequent use of health services.

We also believe that a tax cap could be regressive for the lower income worker.

We also believe that a tax cap could lead to the loss of protection within a group by offering employees a choice of plans; thus, those who perceive themselves as healthier likely would choose the lower cost minimal coverage plan. Less healthy workers likely would choose a more comprehensive benefit high-cost plan—adverse selection as it is known in our business. The spiral would begin.

We also believe that the use of a national limit is inequitable. Unless the level of the cap is regionally adjusted, which indeed is administratively difficult, the tax burden will fall most heavily on workers in higher-cost areas of the nation. These are the areas that least can afford it.

We believe that a tax cap will have a number of adverse effects on employers; by increasing the overall cost of doing business you increase payroll taxes and administrative burdens.

Administratively, a major impediment to implementing a tax cap is the absence, in many cases, of a premium against which to judge an employee's tax liability.

We also believe that a tax cap would make it difficult for employers to insure consistent employee benefits for employees located in different areas of the country.

We also believe that a tax cap could result in elimination of cost-effective benefits. Historically, health insurance was initially chosen to cover the high-cost services such as hospitalization, and only later was it extended to cover lower cost services such as physicians 'office visits, hospital outpatient visits, prenatal care.

The threat of abrupt curtailment of benefits brought about by a tax cap may result in a reversal of that trend.

We also believe that a tax cap may deter the development of new cost-containment strategies. Taking the pressure off the system would stop those who would wish to innovate with cost-control programs because of the administrative expenses associated with those programs.

Finally, a tax cap is not likely to raise the anticipated Federal revenues. We believe that the estimates of revenue to be derived from a tax cap are overstated. Employees, if given the option, will likely shift that part of their compensation above the tax cap to nontaxable fringe benefits. And those who continue to opt for more comprehensive protection and will be subject to taxes are those who anticipate the need for services—the aged, the disabled, and sick workers. You have in effect enacted a "sick tax."

In conclusion, we strongly recommend that Congress not impose a tax cap on employee health benefits. Such a tax would result in little or no overall health cost savings and would do little to raise revenues. It would, however, have several detrimental effects:

The tax cap may result in the elimination of potentially cost-effective benefits, and it would have a disproportionate adverse effect on the aged, ill, disabled, and lower income workers.

Thank you, Mr. Chairman, for the opportunity to present these views.

Senator WALLOP. Thank you, Mr. Tresnowski.

[The prepared statement of Bernard Tresnowski follows:]

TESTIMONY OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, PRESENTED BY BERNARD R. TRESNOWSKI

Mr. Chairman and Members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association, the national coordinating organization for all the Blue Cross and Blue Shield Plans. Today, Blue Cross and Blue Shield Plans serve more than 80 million Americans under our private business and 20 million Americans under our activities as intermediary or carrier for the Medicare, Medicaid and CHAMPUS programs.

We appreciate this opportunity to present our views on the Administration's proposal to cap the tax exemption for employer-paid health insurance premiums. We share your concern about the massive Federal deficit and the need to contain health care costs so that the overall upward pressure on Federal health care expenditures can be slowed. While we believe that changes are needed in some of the incentives present in our health care system, we do not believe that the Administration's current proposal is a well-conceived reform of that system.

Those who favor the tax cap argue that such a cap would ultimately result in greater cost consciousness on the part of consumers about the amount and type of health insurance purchased, and, thus, would contribute to a reduction in health care expenditures and prices. Proponents also argue that, to the extent that it would not cause greater cost consciousness, a tax cap would generate revenues for the Federal government. Finally, regardless of whether or not the tax cap would help contain costs or generate revenues, some proponents argue that it would reform the tax system and correct an inequity enabling persons in higher income brackets to benefit more from the tax exclusion than those in lower income brackets.

We consider the tax cap to be poor public policy—as a cost containment strategy, as a device for generating Federal revenues, and as a reform of the tax system. We believe a tax cap will: (1) Impact workers by having an inequitable and adverse effect on low-income, older and disabled workers, as well as workers who have family members suffering from chronic illness; (2) impact employers by introducing a host of new complications and costs; (3) impact cost containment initiatives by inhibiting the continued development and application of more effective cost containment methods; and (4) probably fail in its objective of raising additional government revenue.

I would now like to discuss these four effects in more detail.

IMPACT OF THE TAX CAP ON WORKERS

Tax cap proponents have argued that the current exclusion disproportionately benefits higher income workers. But, in fact, all non-taxable fringe benefits favor higher income employees. Using this argument to promote the taxation of health insurance obscures significant facts about how the private insurance mechanism works to assure that adequate protection is there for those who need it the most—the sick.

While higher paid workers do receive a relatively greater tax advantage from the current exclusion, a wide range of workers have benefited substantially because comprehensive coverage became accessible to workers who otherwise could not have afforded it. Thus, the exclusion has permitted private insurance to support broader public policy objectives in an appropriate partnership with the government.

Tax experts may debate these questions, but it is at the time of need that the real impact of a tax cap will be felt, and those who would carry the heaviest burden are those who can least afford it.

Adverse effects on older, chronically ill and disabled workers.—In response to a tax cap, employers might reduce their premium contributions by either reducing coverage or by adding more cost-sharing to the insurance package. Either action would have a regressive effect on older, chronically ill or disabled persons. Because their higher illness rates result in more frequent use of health services—and thus higher out-of-pocket costs—they would be paying more for access to health care.

Such a cap also might represent an increased financial burden for those employers who leave aged or disabled employees. The higher health care costs of these employees result in higher insurance costs for all employees in a group. And, to the extent that employment of these individuals raises an employer's health benefit costs above the cap, the amount in excess would be subject to employer-related payroll taxes (e.g., FICA), raising the cost of doing business and possibly eroding corporate profitability.

While we do not have precise estimates of the financial impact of a tax cap on groups with these "high risk" workers, Blue Cross and Blue Shield Association actuarial simulations suggest how the Administration's proposal might affect older workers. The additional taxable income for family Blue Cross and Blue Shield coverage in Florida (with a 75 percent employer contribution) is estimated to be 31 times higher for workers employed in older employee groups (average age 55–64) than in younger groups (average age 35–44)—$1,306 versus $41.

Adverse effects on low-income workers.—The progressive nature of our income tax structure results in any tax exclusion being worth more from a tax perspective to persons in higher income brackets than in lower brackets. The proposed tax cap, however, can be viewed as regressive taxation. According to studies by Gail Wilensky and her colleagues at the National Center for Health Services Research, while a smaller proportion of people with low incomes would be affected by a tax cap, for those affected, it would represent a larger portion of their income as compared to higher income workers. For example, workers who earn less than $10,000 a year would pay an additional $85 in taxes, or an additional 1.4 percent of their income, as a result of the Administration's proposed tax cap. Workers earning more than $50,000 a year would pay $227 in taxes which represents 0.3 percent of their income.

These studies also have shown that employer contributions for health benefits are high for a substantial number of low-income workers. These workers are low wage earners in high benefit industries, for example, entry-level Federal government workers or low wage earners in manufacturing industries. A tax cap could mean a loss of compensation for these workers, unless offset by increases in wages or in other fringe benefits.

Moreover, any employer reaction to a tax cap such as reducing insurance coverage, adding cost-sharing, or raising catastrophic expense limits also would be regressive for low-income workers. Such changes in the benefit package could severely compromise the ability of low income workers and their families to seek needed primary care since they would find it difficult to pay directly for services.

Adverse selection.—One of the underlying assumptions of tax cap proponents is that the tax cap will promote greater consumer choice in the marketplace. If given a choice, they argue, individual consumers will make knowledgeable and economically rational decisions that will set in motion a variety of changes, which eventually will result in lower health care costs.

However, from our experience as insurers, we do not believe that multiple choice results in constructive cost containment. If employers respond to the tax cap by offering employees a choice between lower-cost and higher-cost plans, those who perceive themselves as healthier likely would choose a lower-cost, minimal coverage plan, whereas less healthy workers likely would choose a more comprehensive benefit, high-cost plan. They result of such segmentation of risks and its financial consequences we refer to as "adverse selection." Over time the cost of providing services to the high users drives up the premiums and the healthier workers drop out.

Unfortunately, once an adverse selection dynamic is established, in any group, it becomes progressively worse. A spiral develops in which the experience, and thus the costs, of the segmented groups grow further apart. The financial feasibility of maintaining coverage for the poorer risk groups disintegrates. The principle of group insurance—of spreading the risks widely—is lost. This adverse selection spiral would put the affordability of the more comprehensive, higher-cost option out of reach for the low-income, aged, or disabled worker who needs the protection.

Geographic inequities of a tax cap.—Another inequity arises from the use of a national tax cap. Unless the level of the cap is regionally adjusted, which is administratively difficult, the tax burden will fall most heavily on higher cost areas of the nation. Coincidentally, these are often the very areas which already tend to be suffering the highest levels of unemployment and where employers can least afford any new payroll costs. Moreover, in any region of the country, employers who offer good continuation coverage for laid-off workers would be discouraged from doing so, for the cost of such continuation coverage usually is built into the rates for the regular group coverage.

IMPACT OF A TAX CAP ON EMPLOYERS

A tax cap could have at least three adverse effects on employers by: Increasing the overall cost of doing business through increased payroll taxes and administrative burdens; Preventing uniformity in benefits for geographically dispersed employers; and Complicating labor relations.

A major impediment to implementing a tax cap is the absence, in many cases, of a premium against which to judge an employee's tax liability. The proposed tax cap legislation assumes that employers pay a fixed, monthly premium or contribution for single and family health coverage. This is not a universal practice. Insurers and employers now use a wide variety of mechanisms to price and finance health benefits.

Much of the group health insurance provided today is not based on "premiums" attributable to individuals or families in an employer's group. These non-premium arrangements include: various kinds of self-insurance under which companies pay claims as they are incurred; 501(c) trust funds; "administrative services only" arrangements, under which a carrier performs administrative services but claims are paid by the employer as they are incurred; and others. Often an employer's health benefits will be divided among a number of insurers—different carriers may have coverage for physician care, hospitalization, major medical and dental insurance. The employer may even self-insure for an initial deductible—the first $1,000 or $2,000—in combination with use of multiple carriers.

Even where premiums are established for large groups, they often intentionally are not calculated to reflect real or anticipated costs until well after the close of the contract year. This is necessary to enable insurers to compete with self-insured programs which focus on the employer retaining and earning interest on his cash.

Thus, these commonly used financing arrangements do not lend themselves to determining a premium amount which is reliable or equitable enough for employers to use in computing employee taxable income.

Even if an equitable premium could be established without radically changing the way employee benefits are financed, employers would face other administrative problems. Many companies have operations in several areas, with more than one insurance carrier or with different benefits plans for different classes of employees. Complex record systems would have to be established to accommodate all these differences in calculating taxable income for employees.

In addition, a tax cap on health insurance premiums could increase employers' overall cost of doing business. To the extent that any employer's contribution to employee health insurance premiums were to exceed the cap, the excess contribution would be subject to additional payroll taxes (e.g., FICA and unemployment). Alternatively, employers might respond to the preferences of certain employee groups by providing lower health insurance premium contributions (below the cap) and additional wages. These additional wages would be subject to payroll taxes.

If these increases in company administrative and payroll costs could not be passed on to the consumer in the form of higher prices or be borne by employees in the form of lower compensation, corporate earnings would diminish.

A tax cap might also pose significant equity issues for employers who have operations in different states or even in different areas in the same state. Since health insurance premiums for the same benefit package can vary dramatically across the nation and between urban and rural areas, a tax cap might result in additional taxes for employees in one area but not in others. Employers would find it extremely difficult to assure equal benefits throughout their companies.

Finally, under the Administration's bill, employers might find themselves faced with the prospect of having to reopen collective bargaining negotiations on contracts entered into after January 31, 1983. For example, a recent contract between the steelworkers union and management specifically included a provision that if a new tax cap bill is passed, the union and the companies will "meet to consider revisions which would minimize worker tax liability."

USE OF TAX CAP AS A COST CONTAINMENT DEVICE

Proponents of a tax cap argue that it would reduce the rate of increase in health care expenditures by promoting greater cost-sharing. While we would agree that a tax cap may accelerate the trend to greater cost-sharing, and thus may reduce expenditures for health insurance premiums, we do not believe that it would result in substantial savings in total health care expenditures. Rather, we believe that a limitation on health insurance premiums would not contain total health care costs because it could: Result in elimination of the most cost-effective benefits; Discourage certain cost containment activities.

Elimination of cost-effective benefits.—We are concerned that abruptly imposing a limit on employer-based health insurance may result in elimination of or reduced coverage for those benefits which have a lower cost per unit of service such as preventive care, outpatient physician services and home health care. Employees, historically, have been most concerned about retaining maximum coverage for hospital inpatient care and other more financially threatening medical expenses. Just as insurance was initially chosen to cover the highest cost services—such as hospitalization—and only later was extended to cover lower cost services such as physician office visits, hospital outpatient visits and prenatal care, abrupt curtailment of benefits may result in a reversal of that pattern of coverage.

Yet it is expanded coverage for selected outpatient, lower-cost services which appears to be effective in containing costs over the long-term. A recent Johns Hopkins University Study indicates that the increase of outpatient care coverage by Blue Cross and Blue Shield Plans across the country resulted in the substitution of these services for expensive inpatient care, and contributed to a steady decline in Blue Cross inpatient admissions during the period of 1970–79. Throughout this period, Blue Cross admission rates declined by about two-thirds of one percent annually, whereas comparable admission rates for the general population under age 65 were rising at a rate of 1.3 percent each year.

We believe that while some savings in premium expenditures might be realized in the near-term, the effect of a tax cap on efforts to control total health care expenditures could be counter-productive. The greater part of the health cost problem—institutional costs—may remain largely untouched.

Discouragement of cost containment activities.—We believe that tax caps may deter, in some cases, insurers and employers from developing new cost containment strategies. In recent years, insurers have pursued a variety of innovative cost control programs which are, or have promise of, holding down health care costs. For example, our Plans have developed a variety of programs such as utilization review, medical necessity review, and promotion of new benefit design packages to shift hospital care to appropriate lower-cost settings. Blue Cross and Blue Shield Plans have invested heavily in the development of alternative delivery systems to help control health costs. Indeed, our Plans are the most prolific developers of health maintenance organizations. Also, a number of Blue Cross and Blue Shield Plans are offering or developing preferred provider arrangements.

Development of these innovative cost control programs is expensive, particularly during the start-up period. If a tax cap is imposed, employers and insurers would have less incentive to incur the costs of such programs in the hope of future savings. A real question for an employer or insurance company would then be whether the benefits to be gained from cost containment activities can be clearly shown to be greater than those to be achieved by simply raising employee cost-sharing.

Finally, it would be simplistic to assume that insurance is the only driving force in rising costs. Rising personal incomes, rising expectations about health, increasing advances in science and medicine, development of more intensive medical care services and products, general inflation in the economy, and the aging of our population all have contributed to rising costs. Public and private policies of past decades to expand the supply of health resources and to promote health insurance coverage in order to provide greater access to health services also contributed to increased utilization.

Moreover, insurers have a tradition of competing to offer the public and employer groups the products most desired. Until recently, cost containment was not a high priority, but now, it is the predominant focus in our industry, and is having an impact.

In our own case, we know that the growing sophistication of our medical necessity evaluations, the wider application of new benefit and utilization control programs, and the development of tighter contractual arrangements with providers are enabling Blue Cross and Blue Shield Plans to exercise more control over some of the less tractable sources of increasing expenditures. Our experience in provider contracting and in applying cost containment programs to diverse settings will help us develop even better capabilities. The forces of competition are leading other carriers and providers to strive for improved results.

EFFECT OF TAX CAPS ON FEDERAL REVENUES

We believe that the estimates of revenues to be derived from a tax cap are overstated. Recent experience with flexible benefit plans leads us to believe that employees, if given the option, may shift that part of their compensation above the tax cap to non-taxable firing benefits. It also should be noted that a tax cap may actually promote the development of new non-taxable benefit programs.

The revenues produced from a tax cap would be far less than projected and, more importantly, would be largely derived from those who are among the more vulnerable in our society—the older, sick or disabled workers and their families who, because of their perceived medical needs, choose more comprehensive health care coverage.

SUMMARY

In conclusion, we strongly recommend that Congress not impose a tax cap on employee health benefits. Such a tax would result in little or no overall health cost savings and would do little to raise revenues. It would, however, have several detrimental effects: a tax cap may result in the elimination of potentially cost-effective benefits and it would have a disproportionate adverse effect on aged, ill, disabled and lower-income workers.

Also, while the Administration states that it wants to limit tax increases, the proposed tax cap is clearly a new tax on working Americans.

STATEMENT OF BURTON H. PRESS, PRESIDENT, AMERICAN DENTAL ASSOCIATION, WASHINGTON, D.C.

Dr. PRESS. Mr. Chairman, I am Dr. Burton Press of Walnut Creek, Calif., president of the American Dental Association, representing 135,000 dentists.

I would like to commend all of those who have supported the longstanding Federal tax policies that have encouraged the private sector to provide health benefit protection to over 186 million American citizens.

Under S. 640, employees would be taxed for the first time on a portion of the contribution their employers make to family or individual health benefit plans. The theory of those who support the proposal is that this new tax will help control rising health care costs by inducing employees to make decisions to enroll in plans requiring more personal financial obligations and providing less first-dollar coverage of benefits, and that additional Federal tax revenues would be made.

Mr. Chairman, S. 640 will not achieve these objectives.

More importantly, however, we are certain that it will penalize prevention-oriented cost-effective dental prepayment plans and thus have an adverse effect on the oral health of millions of present and potential beneficiaries of such plans.

It's a well known fact that the highest rates of inflation in the health care field have been associated with the costs of hospital and major medical care. Because of the financial risks, because they are greatest for hospitalization and major medical care, beneficiaries can be expected to retain the most comprehensive coverage possible.

It is totally unrealistic to assume that beneficiaries will undertake greater financial responsibilities for unpredictable hospital and major medical expenses when they can fall below the tax threshhold by foregoing other health benefits such as dental care.

The independent studies already quoted by the Rand Corporation and by the Congressional Budget Office confirm the conclusion that a tax on health fringe benefits would affect hospital coverages the least and coverage of dental services and prescription drugs the most.

In other words, S. 640 will not have an appreciable impact upon hospital expenses, the primary cause of increasing health care, but it will have an adverse effect on dental and other similar noninflationary coverages.

Dental prepayment plans, which are structured to include patient participation features such as deductibles, copayments, and maximums, could serve as the model for controlling costs in other areas.

In the last 15 years the number of individuals covered by dental plans has increased from 6 million to almost 90 million. During that period, dental fees increased at a rate below the Consumer Price Index. Hospital charges increased by 360 percent, and physicians fees by 190 percent.

Dental benefit plans are not part of the problem and should not be placed in jeopardy by a change in tax policy that misses the target. If first-dollar coverage of hospital and major medical expenses is the problem, then it should be addressed directly and specifically. I noted with great interest this morning that my friends in AMA and AHA had no problem with this legislation.

We will revert to 30 years ago when the people will wait with their dental problems until crisis intervention is necessary and will present themselves at the office requiring extensive care at more cost without coverage. We seriously question projections that have been made regarding the Federal revenue that will be generated. We support the conclusions of other testimony today which suggests that shifts from taxed to nontaxed fringe benefits will occur precluding any significant revenue gains.

Mr. Chairman, dental health should not be penalized because 30 years ago we did what you are trying to get hospitals and medical insurers to do now.

Thank you.

Senator **Wallop**. Thank you, Dr. Press.

[The prepared statement of Burton Press follows:]

STATEMENT OF AMERICAN DENTAL ASSOCIATION

Mr. Chairman and Members of the Committee: I am Dr. Burton H. Press of Walnut Creek, California. As President of the American Dental Association, representing more than 135,000 members, I appreciate this opportunity to present our views on S. 640, the Health Cost Containment Act of 1983.

Mr. Chairman, I would like to begin my brief presentation by commending all of those who have supported the long-standing federal tax policies that have encouraged the private sector to provide health benefits protection to over 186 million American citizens.

We believe this has been a wise policy and that it would be a grave and perhaps irreversible mistake to alter it without giving serious consideration to the health consequences that would follow.

Under the provisions of S. 640, employees would be taxed for the first time in history on a portion of the contribution their employers make to family or individual health benefits plans.

As we understand it, the "theory" of the economists and others who support this proposal is (1) that this new tax will help control rising health care costs by inducing employees individually and collectively to enroll in plans requiring more personal financial obligations and providing less first dollar coverage of benefits and (2) that additional federal tax revenues will be raised.

Mr. Chairman, we respectfully submit that S. 640 will not achieve either objective. We do not believe it will be effective in controlling rising health care costs. We do not believe it will generate the projected revenues. More importantly, however, we are certain that it will penalize prevention-oriented, cost-effective dental prepayment plans and thus have an adverse effect on the oral health of millions of present and potential beneficiaries of such plans.

To elaborate briefly on these conclusions; first, it is a well known fact that the highest rates of inflation in the health care field have been associated with the costs of hospital and major medical care.

A second obvious fact is that because the financial risks are greatest for hospitalization and major medical care, beneficiaries can be expected to retain the most comprehensive protection possible.

With regard to S. 640, it would appear totally unrealistic to assume that beneficiaries would undertake greater financial reponsibilities for unpredictable hospital and major medical expenses when they can fall below the tax threshold by foregoing other health benefits such as dental care. Independent studies by the Rand Corporation and the Congressional Budget Office have confirmed the conclusion that a tax on health fringe benefits would affect hospital coverages the least and coverage of dental services and prescription drug coverages the most. In other words, S. 640 will not have an appreciable impact upon hospital expenses, the root cause of increasing health care costs, but will have an adverse effect on dental and other similar non-inflationary coverages.

In this latter connection, it should be of interest to the Committee that dental prepayment plans, which are structured to include patient participation features such as deductibles, copayments and other limits, could serve as the model for controlling costs in other areas. Over the last 15 years, the number of individuals covered by dental plans has increased 1500 percent, from 6 million to nearly 90 million people. During that same period, dental fees increased at a rate below the 165 percent increase for all goods and services as measured by the CPI. Hospital charges increased by 360 percent and physicians' fees by 190 percent, during the same interval. Appended is a graph demonstrating a similar pattern for the years 1970–82.

Mr. Chairman, the foregoing facts and figures, we believe, demonstrate that dental benefits plans are not part of the problem, and should not be placed in jeopardy by a change in tax policy that, with all due respect, misses the target. If first dollar coverage of hospital and major medical expenses is the problem then it should be addressed directly and specifically and not by the imposition of a general tax on health fringe benefits.

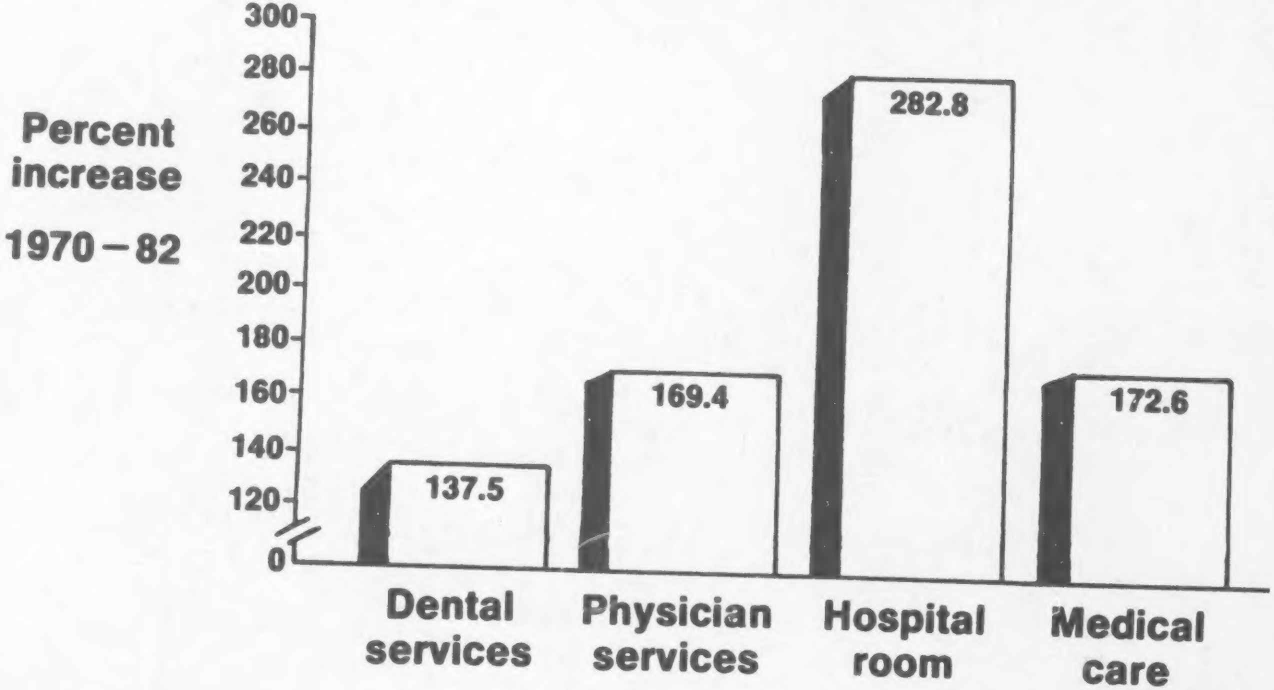
The fact is that beneficiaries of dental prepayment plans receive preventive dental care on a more regular basis than do people not covered by such plans. This is not only cost effective but results in improved life-time oral health. We think this should be encouraged rather than discouraged by federal tax policy. The patient who discontinues dental insurance to stay within the tax free "cap," and who subsequently foregoes lower-cost preventive care, faces the possibility of more costly treatment later for disease that might have been prevented or at least detected in an incipient stage. This potential health consequence of taxing health insurance must be given serious consideration by this committee. Indeed, such taxation could be of great economic consequence to many patients who would end up paying more later for the disease that might have been averted had they retained their dental prepayment coverage.

Finally, Mr. Chairman, we question seriously the projections that have been made regarding the federal revenue that will be generated from the proposed new tax. In our opinion, shifts from taxed to non-taxed fringe benefits will occur, precluding any significant revenue gains.

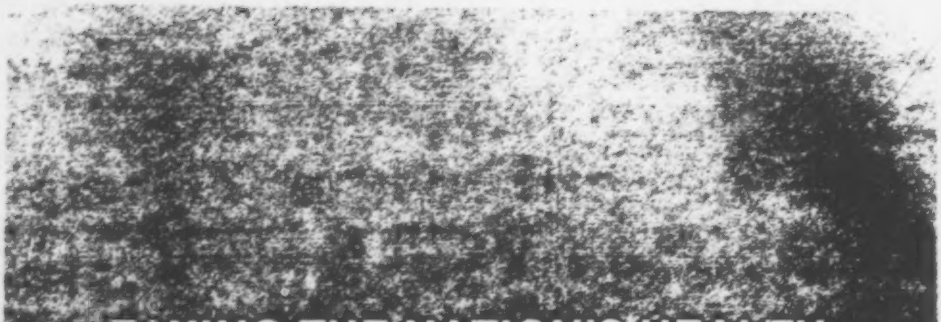
I will be happy to answer any questions the Committee may have. Thank you.

CONSUMER PRICE INDEX AVERAGES

Percent increases for selected items
1970 - 82



Source: U.S. Department of Labor

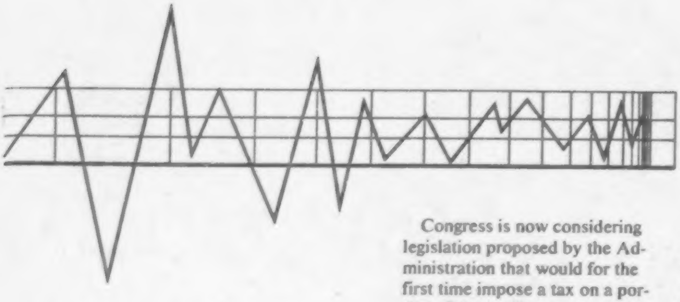


TAXING THE NATION'S HEALTH

An Analysis of Health Incentives Reform Legislation

American Dental Association
1101 17th Street, N.W.
Suite 1002
Washington, D.C. 20036

April, 1983



An introduction

Congress is now considering legislation proposed by the Administration that would for the first time impose a tax on a portion of the health care insurance coverage employees receive as fringe benefits from their employers.

If enacted, this legislation would have a detrimental effect on the nation's health and would not control the high cost of health care, despite the Administration's claims to the contrary.

The American Dental Association strongly opposes any tax on the health of American people.

In addition to this fundamental concern, the Association's objection to this particular plan focuses on three major shortcomings of the proposal:

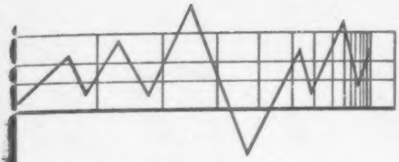
- The tax will not have a significant effect on those elements of the health care sector which are most inflationary such as hospital costs;
- The tax will threaten the availability of preventive, cost-efficient benefits such as dental prepayment;
- The tax will not raise projected revenues due to expected benefit shifting, with employees trading health benefits for nontaxed fringe benefits.

Although the Administration has cited health care cost control and revenue enhancement as justifications for offering the proposal, this tax on health will not in fact meet the Administration's objectives.

But such a plan would have a serious, negative impact upon the nation's oral health. Years of progress in combating oral disease, progress directly linked to the growth of dental prepayment plans, may yield to years of deteriorating oral care.

The American Dental Association calls upon Congress to join us in opposition to this proposal.

Why the American Dental Association opposes the proposed tax on health benefits



The health benefits tax

The American people are deeply concerned about the rising cost of certain types of health care. Last year, medical services costs increased nearly three times as rapidly as the Consumer Price Index. The burden of this ever-rising expense is felt in every sector of our economy and is reflected in the high cost of health insurance.

To address this national problem, the Administration has proposed a series of measures that have been characterized as a "cost containment" package. Among these is a proposed amendment to the Internal Revenue Code that would impose a tax on a portion of the health care coverage employees receive from their employers as fringe benefits.

Under current law, employer contributions to employee health benefit plans are not taxed.

Under the Adminstration's plan, health care benefits would be regarded as taxable income for the first time in history.

Employees with families would be taxed on the amount of employer contributions for health benefits exceeding $175 per month in 1984; for individuals, the benefits ceiling, or "cap," would be $70 per month in the first year. By treating employer contributions as taxable employee income, the amounts also would be subject to Social Security tax payments.

The American Dental Association and its 140,000 members share the nation's concern with rising health care costs and the accompanying upward spiral in health insurance premiums. But we question the wisdom of this approach as a remedy for these complex problems.

The most inflationary health costs will not be controlled

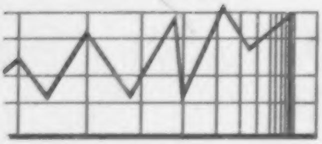
A tax on health benefits would discourage private sector involvement in financing health care needs, encourage workers to neglect their health and reward extravagance in health care benefit plans while penalizing thrift.

The tax proposal has been offered to curb inflationary, expansionist trends in health benefits systems. In reality, it actually may contribute to these trends by favoring those health services and benefit plans that have been among the most inflationary—hospital and major medical care.

The proposed tax would force American workers to choose among various health benefits. To insure against catastrophic illness and injury, it is possible that most employees will retain major medical and hospital coverage but give up other health benefits in order to avoid added taxes.

In contrast to dental plans, traditional hospital and medical insurance plans generally do not include a financial incentive to stay healthy, nor do they encourage subscribers to exercise discretion in the use of medical services. Co-payment for major medical procedures usually is not required, and this lack of financial incentive tends to result in what the Administration terms "excessive" use of health benefits.

A tax that favors these major medical and hospital benefit plans will feed the inflationary spiral, an effect that runs contrary to the Administration's stated cost-containment goal.



Cost-efficient benefits such as dental prepayment will be jeopardized

These plans hold down the cost of dental services by encouraging subscribers to seek preventive care. Through co-payment requirements, they contribute less to inflation than other health care plans.

Dental benefit plans actually help to control dental costs by rewarding patients who take care of their teeth in order to avoid oral diseases requiring costly restorative care.

Consider the following:

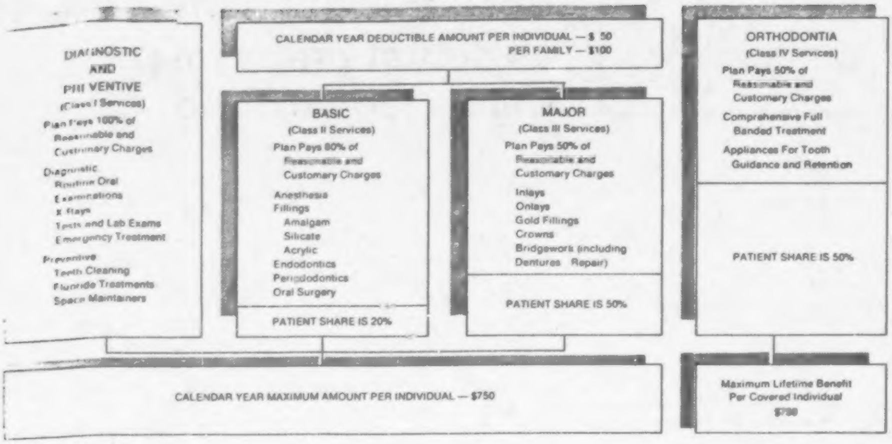
- Major dental benefit plans generally cover 100 percent of the cost for diagnostic and preventive treatment—routine oral exams, teeth cleaning, fluoride treatment and other types of care intended to help patients stop dental diseases before they start.
- As treatment requirements become more costly and complicated, patients must pay a larger share of the cost. Major plans generally provide higher levels of benefits for basic restorative services (tooth fillings, for example) than for major restorative treatments such as crowns and bridges.
- This method of weighting benefits assures that all plan subscribers maintain a financial interest in their oral health—and share the cost of restoring it when disease occurs. If patients fail to properly care for their teeth, they will have to pay more out of their own pockets.

The following statistics clearly demonstrate the success that dental plans with these features have had in restraining costs:

- During the decade ending last year, the Consumer Price Index increased by 130.7 percent. For dental services the increase was only 114.4 percent. In the same period, the cost of physician services increased 144.5 percent; the cost of all medical care rose 148.1 percent; and hospital room rates climbed a whopping 220.1 percent.
- The number of individuals covered by dental prepayment plans has grown by more than 1,000 percent, from about six million to 87 million, in the last 15 years. And during this period of unprecedented growth in dental plans, per capita dental premium costs actually declined, according to the Health Insurance Association of America. Co-payment requirements featured in dental benefit plans have helped control dental service costs by encouraging workers to care for their teeth. Patients are more likely to preserve their good health when they know that failing to do so will cost them more money.

Despite this success of dental prepayment in increasing demand for care, controlling costs, and leading to better oral health, the tax would provide incentives for employees to forego these plans but maintain hospital and medical coverage.

EXAMPLE OF A DENTAL BENEFITS PLAN


DIAGNOSTIC
AND
PREVENTIVE
(Class I Services)
Plan Pays 100% of
Reasonable and
Customary Charges
Diagnostic
Routine Oral
Examinations
X Rays
Tests and Lab Exams
Emergency Treatment
Preventive
Teeth Cleaning
Fluoride Treatments
Space Maintainers
CALENDAR YEAR DEDUCTIBLE AMOUNT PER INDIVIDUAL — $ 50
PER FAMILY — $100
BASIC
(Class II Services)
Plan Pays 80% of
Reasonable and
Customary Charges
Anesthesia
Fillings
Amalgam
Silicate
Acrylic
Endodontics
Periodontics
Oral Surgery
PATIENT SHARE IS 20%
MAJOR
(Class III Services)
Plan Pays 50% of
Reasonable and
Customary Charges
Inlays
Onlays
Gold Fillings
Crowns
Bridgework (including
Dentures Repair)
PATIENT SHARE IS 50%
ORTHODONTIA
(Class IV Services)
Plan Pays 50% of
Reasonable and
Customary Charges
Comprehensive Full
Banded Treatment
Appliances For Tooth
Guidance and Retention
PATIENT SHARE IS 50%
CALENDAR YEAR MAXIMUM AMOUNT PER INDIVIDUAL — $750
Maximum Lifetime Benefit
Per Covered Individual
$750

Projected revenue gains will not be met due to fringe benefit shifting

The Administration has cited revenue gains as a primary reason for the imposition of a tax on health benefits. However, these projections do not take into account the very strong likelihood that employees and employee groups subject to the tax will shift away from taxable health benefits to nontaxable benefits.

Employees will trade certain health benefits, such as dental coverage, for other nontaxed fringe benefits to reduce their taxable income. The Administration acknowledges that workers may relinquish some health benefits in favor of higher wages or an extra week of vacation.

The health benefits tax will place strong pressures on employers to shift their contributions to nontaxed fringe benefits. By shifting from taxable health benefits to other nontaxable fringe benefits, the dental care of millions of our citizens will suffer a serious setback, and the dramatic predicted increase in revenue to the Treasury will not be realized.

A tax on health benefits would not meet the Administration's objectives.

Studies by the Congressional Budget Office and the Rand Corporation question tax's usefulness

The Congressional Budget Office (CBO) found that legislation in the 97th Congress that included a similar tax would have favored those services that are "expensive, nonelective and not predictable" and adversely affected those health services where concern with spiraling costs is least intense.

"Those employees who increased their cost sharing are likely to concentrate the increase on those services where insurance is least valuable," the CBO said. "This means that dental services and prescription drug coverage are likely to be reduced by the greatest portion and hospital coverage the least."

So it is clear that such "cost-containment" measures as the proposed tax would do almost nothing to control the high cost of hospital coverage, which the Budget Office cited as the most inflationary health benefit.

In February, the Rand Corporation published an analysis of a tax on health care based on data from its own Health Insurance Study (HIS). Rand served as insurer for three-year and five-year periods for 7,706 people in six localities. Coverage included dental and several other health care services under four types of plans with varying deductibles and co-payments.

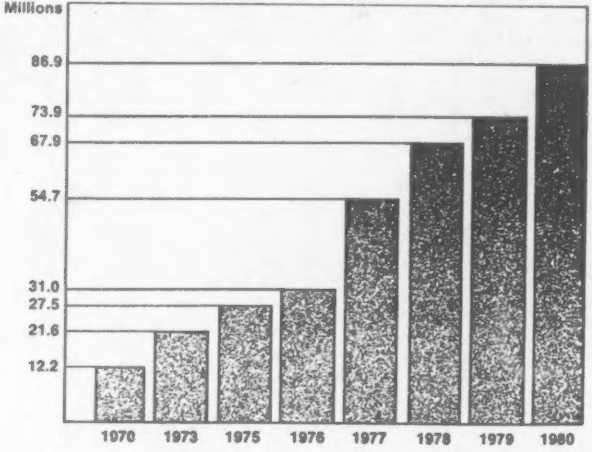
According to the Rand report, a tax on health benefits would result in the following:

- Lowered utilization of health services;
- Reduced acceptance of certain types of health coverage, including dental coverage.

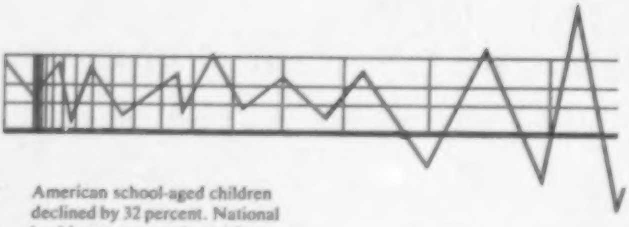
Rand also said that lowered utilization of health services could "adversely affect the health status of employees and their dependents." In other words, if health benefits are taxed, we can expect an increase in disease as workers are encouraged to trade health fringes for other nontaxed benefits.

A long-term look at the potential effects of a tax on health benefits yields some startling revelations.

Number of Americans with Dental Insurance Coverage



The issue is health



Unlike catastrophic illness or injury, dental disease is a certainty, a chronic health problem affecting nearly everyone—man, woman and child.

Fully 98 percent of Americans are subject to dental disease in some form—tooth decay, periodontal (gum) disease, oral cancer (which this year will kill more than 9,000 U.S. residents) and many others.

Despite the high prevalence of these diseases, dentists greatly have reduced the severity of oral illness, largely by concentrating their efforts on prevention.

Prevention is the watchword of modern dental treatment and a factor strongly emphasized in dental benefit plans. From the standpoint of health cost control, it is better to prevent a cavity than to fill one—an approach to dental care that has paid off in reduced dental disease and improved health overall.

In the decade of the 1970s, the incidence of tooth decay in American school-aged children declined by 32 percent. National health surveys conducted from the 1950s through the 1970s show considerable progress in the war against gum disease, which afflicts at least three out of four people over 35 and is the major cause of tooth loss in adults.

These improvements in oral health clearly demonstrate the value of a preventive approach to dental care. Moreover, these reductions in dental diseases coincide with a dramatic rise in the numbers of Americans having dental coverage.

The connection seems clear:

Dental benefit plans offer the most cost-effective and successful available means of combating oral disease.

Incentives to reduce the level or availability of dental benefits will result in a decline in the oral health of Americans.

Dentistry has a proven track record in disease prevention and treatment.

In the final analysis:

- The tax will not control health costs significantly.
- The tax will not generate the predicted revenue.

Why then jeopardize dental care for the 87 million people currently enrolled in dental plans and discourage millions more from obtaining prepaid dental coverage?

We urge Congress to reject the proposal to tax health benefits.

Senator Wallop. Senator Packwood.

Senator Packwood. Dr. Press, you and Mr. Tresnowski and Mr. Troy all, in one form or another in your testimony, indicate that the natural tendency of things if this bill passes will be to drop dental care, secondary care, tertiary care, in preference to keeping hospital care, probably because of the fear of the cost of hospitalization. Do I state it right, Dr. Press?

Dr. Press. I think so.

Senator Packwood. And I think you are probably right. It would seem to me logical that if somebody has a fear in the back of their mind it is for example the fear of breaking their back, spending 9 months in a hospital, and being wiped out. And while indeed they know they should treat their children's teeth, or they know that they should see an ophthalmologist, those are once a month costs or twice a year costs, and if they have to make a choice between the two, even though the ultimate cost of not taking care of your teeth may cost a lot down the road, the fear of hospitalization seems relatively more important. And I think human nature is aiming in exactly the direction you said.

But, Mr. Troy, I want to ask you specifically—you comment as follows:

> Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment—the employers, the unions, the insurers, in essence all of those in the private sector on the paying side of the equation say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment. On the other hand, those who have the most to gain by its failure to work, that is, the health providers, say it will work to de-escalate hospital inflation.

Do you think that the hospital associations, both public and proprietary hospitals, and to somewhat lesser an extent the American Medical Association, have reached their position out of a fear that we are going to try to enact some kind of medical cost-containment, and better it adversely affect you than them?

Mr. Troy. I would say that, in terms of the hospitals lobbying against the application of prospective reimbursement on an all-payor basis, the hospitals want it limited to medicare so that if the medicare squeezes the DRG's the hospitals will have the option of rasing prices to the rest of the third-party payors. They find an all-payer proposal to be much more troublesome than this proposal, which is certainly the lesser of the evils in their minds.

On the other hand, since we think the all-payor DRG or any kind of an all-payor prospective reimbursement system would do more for health cost-containment, particularly hospital cost-containment, we favor that proposal over this proposal.

Senator Packwood. Mr. Troy and Mr. Tresnowski would you both address yourselves to the comment Dr. Strain raises, that your policies are adverse to the interest of children's health, or at least don't cover them as fairly or as equally as you do adult illnesses.

Mr. Troy. Senator, I think the private marketplace is involved in the selection of preventive care, immunizations, well-baby care, as part of the benefit package.

In Travelers we offer well-baby care as a standard part of our small group program.

Senator PACKWOOD. As a standard part of what?

Mr. TROY. Of our program for small employers, our small group program. Naturally with the largest employers, we respond to their proposals.

Senator PACKWOOD. Do you mean the largest employers say, "We want a package that covers the following, and we've got 122,000 employees," and you tailor your policy to that?

Mr. TROY. That's right. But it is at additional cost. I would agree that in terms of total cost it's a modest cost—maybe less than $5 a month to add a benefit which would include immunizations and that kind of well-baby care. However, it is a choice that the employers are making in terms of the rest of their benefit package.

Senator PACKWOOD. Then you are basically saying the employers and the unions are not really requesting this kind of a benefit, by and large?

Mr. TROY. Well, we sell a lot of it, Senator. And as I say, it's a standard part of our small group packages. We have 70,000 small groups covered, so we are selling a lot of it; but I would admit, that there are an awful lot of large plans that do not cover immunizations, for example.

Senator PACKWOOD. Mainly because as you say, they don't ask for it. You would tailor your policy to it if they requested it?

Mr. TROY. Yes; we have it for sale. We have a price, and it is for sale.

Senator PACKWOOD. Mr. Tresnowski, would you comment?

Mr. TRESNOWSKI. Yes.

I have engaged in an exchange of correspondence with the American Academy of Pediatrics for the past year on this subject and have provided evidence to the American Academy of broad coverage in the area of pediatrics.

The product is available in the marketplace; the problem is it isn't bought. I think the argument that Dr. Strain made probably supports more than anything I could have said, "What kind of decisionmaking would take place under a tax cap?"

When you put the products in the marketplace the buyer will move in the direction of buying those benefits of most concern to their employees or other groups. And in this case they have opted for extensive hospitalization coverage. And they do that, often, at the price of other modalities of care—out of hospital services, physician office, and so on—but the product has always been available.

Senator PACKWOOD. Dr. Strain, would you address yourself to this exchange of correspondence you have had with Mr. Tresnowski and comment on what the last two speakers have said?

Dr. STRAIN. Yes.

I think there is no doubt that this is available through insurance companies. It is not very well marketed. We know in the office setting that most of the care provided in the ambulatory setting—both preventive and treatment of acute illnesses—is not covered by insurance.

I think it has to be more actively marketed. It has to be a requirement, in our opinion. It could be included in a package.

Senator PACKWOOD. Excuse me. A requirement?

Dr. **Strain**. That the policy should not discriminate against children by excluding preventive health services as part of the package.

The cost is minimal. The cost is really quite minimal. But in our experience, the health insurance industry has not marketed this very actively, and we feel that there has to be some compensatory changes. Obviously people are going to have to be covered for hospitalization, but this could be perhaps dealt with on a copayment or a deductible type of cost-control and at the same time add preventive health services or have the preventive health services as part of the package that would be offset by the deductibles and the copayment in the hospitalization.

We think it is a terribly important thing to have preventive health services for children. We think it does reduce the future illnesses and hospital care in the future.

Senator **Packwood**. Thank you.

No further questions, Mr. Chairman.

Senator **Wallop**. Would it be a fair thing to say that none of the witnesses presently at the table are supporters, either presently or in coffee-cup sessions, of a flat tax?

Mr. **Troy**. In my case, Senator, yes.

Senator **Wallop**. I didn't think any panelist is a supporter of the concept of a flat tax or clearly any variation on that. And I must say that I have a good many letters from the medical profession of all types in Wyoming supporting a flat tax.

Senator **Packwood**. Malcolm, I'll bet you anything, though, when you get those letters, that they are not thinking of fringe benefits as taxable income.

Senator **Wallop**. Well, you have to assume that if you are not talking about it as income then you are not talking conceptually of a flat tax.

I believe that at least some professional organizations are on record as supporting that, in concept. So you might look homeward to consistency in it. I mean, it is the problem that we face with any such concept.

Mr. Tresnowski, you were talking about the discrimination that would arise out of the taxation of benefits within higher-cost and lower-cost areas for hospitalization in the nation.

Let me ask you this: Is it your point that insurance plans have no effect on hospital costs?

Mr. **Tresnowski**. That insurance plans have no effect on hospital costs?

Senator **Wallop**. Is that your point?

Mr. **Tresnowski**. No; it's not my point. My point is that you've got regional variation in the cost of health care, and therefore in the premium charged. So if you have a tax cap set at $2,100 in South Carolina, that may cover the full scope of the benefits; whereas, in New York City it may cover only half the scope of the benefits.

So the burden of that tax falls heavier on the people in New York than it would in South Carolina, for example.

Senator **Wallop**. But this is the chicken and the egg question, is it not?

If insurance plans as they are administered from region to region and State to State around the country in their discrimination or lack of discrimination, in what they pay and how they pay it, have an effect on hospital costs, could it be said that something like this would tend to level hospital costs throughout the Nation?

Mr. TRESNOWSKI. I don't think so, because, if you look at a hospital's costs, 70 percent of their cost is labor cost, and the variation in my example between South Carolina and New York would be simply associated with the variation in labor costs in those two communities.

Senator WALLOP. What percentage of a hospital bill is labor cost?

Mr. TRESNOWSKI. Seventy percent.

Senator WALLOP. Seventy percent of a hospital bill is labor cost?

Mr. TRESNOWSKI. Seventy percent of a hospital's costs are labor costs.

Senator WALLOP. I would like to see statistics sustaining that argument. I don't think it can be made.

Mr. TRESNOWSKI. Well, I would be glad to supply those.

Senator WALLOP. Would you do that for the committee?

Mr. TRESNOWSKI. Sure.

[The statistics follow:]

Blue Cross
and
Blue Shield
Association

Bernard R. Tresnowski
President

676 North St. Clair Street
Chicago, Illinois 60611
312/440-6010

July 14, 1983

The Honorable Malcolm Wallop
United States Senate
210 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Wallop:

During the Senate Finance Committee's June 22, 1983, hearing on taxation of fringe benefits, you requested statistics on the percentage of total hospital expenses attributable to labor costs.

There are a number of ways that labor costs can be defined for this purpose. The Health Care Financing Administration, in its marketbasket analysis of price trends in the hospital industry, considers 77 percent of hospital expenses in 1982 to be sensitive to local labor costs. The elements of hospital expenses included in this definition are:

Wages and salaries	51.6%
Employee benefits	8.4%
Professional fees	4.8%
Business services	4.3%
Other miscellaneous expenses	7.5%
Total labor related	76.6%

If a more narrow definition is followed incorporating only wages and salaries, employee benefits and professional fees, the percent drops to about 65 percent.

Finally, I would like to note that in an unpublished study of the variation by hospital in Medicare costs per admission, it was found that approximately 80 percent of the variation in costs could be explained by differences in area wages. This study was conducted by Gerard Anderson, formerly with the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and currently with the Johns Hopkins University.

If I can provide further information on this issue, please do not hesitate to contact me.

Sincerely,

Bernard R. Tresnowski

Bernard R. Tresnowski

Senator **Wallop**. Mr. Troy, your statement says, "The most sensible approach to keeping hospital costs under control is prospective pricing reform." Would you describe what you mean by that?

Mr. **Troy**. Well, Senator, we have been following very closely the hospital prospective systems in Maryland, New Jersey, Massachusetts, New York and in Connecticut, and we feel that these systems in effect apply incentives for reduced hospitalizations, lengths of stay, and overall budget control to the whole hospital industry and have been effective. And of course medicare now, with the social security amendments, is moving to a diagnosis-related grouping prospective-reimbursement program for medicare.

We applaud the Congress for moving in that direction, and we say if it's good for medicare then it should be good for all patients as an effective cost-control mechanism.

Senator **Wallop**. Would Travelers then support national legislation requiring prospective pricing reform in hospitals?

Mr. **Troy**. Yes. We support strengthening the medicare amendments establishing DRG's.

Senator **Wallop**. What about generally?

Mr. **Troy**. Pardon me?

Senator **Wallop**. What about generally? Because this is in effect a hearing on things beyond medicare benefits. what about generally? Would Travelers support legislation, national legislation, requiring uniform prospective pricing?

Mr. **Troy**. Yes. We would like to see the medicare amendments broadened so that there are more incentives in the States to adopt all-payor systems for hospital reimbursement.

Senator **Wallop**. Can I restate the question, then? Can we leave medicare out of it? I am asking you about generally in the Nation. Is it Travelers testimony here today that they would support congressionally mandated or statutorially mandated prospective pricing reform in hospitals across the Nation?

Mr. **Troy**. Yes; but we think that these systems should vary by different State methods; there shouldn't be one single system for the entire country, as the four State systems do vary now—the ones in Maryland, New York, Massachusetts, and New Jersey.

Senator **Wallop**. How would Congress arrive at such a position?

Mr. **Troy**. By providing greater incentives for the States to develop their own systems, and then have the medicare and medicaid programs participate in those State systems.

Senator **Wallop**. I wish you would leave medicare and medicaid out of it just for the moment and answer my question as to hospital cost containment through the mechanism that you suggest is good, as prospective pricing reform.

Mr. **Troy**. Well, we think that these all-payor prospective reimbursement systems should be handled at the State level, but since the medicare and medicaid patient load constitutes 42 percent of the patient days, it's impractical for a State to move on hospital cost-containment unless the medicare and medicaid programs participate. So that's where the tie-in comes in.

Senator **Wallop**. Well, I understand that. But we are talking about what kind of legislation you would support nationally, and I suspect I won't get an answer to that today.

Mr. TROY. We have proposed amendments to the medicare DRG prospective reimbursement program that would provide more incentives for States to develop systems for the nonpublic patients. I would be glad to supply you with those.

Senator WALLOP. Thank you all very much.

Mr. TROY. Thank you, Senator.

Senator PACKWOOD. The next panel consists of Mr. Peter Kelly, Mr. John Blossom, Jr., and Mr. Paul Huard.

Mr. Kelly, why don't you go right ahead?

STATEMENT OF PETER M. KELLY, KIRKLAND & ELLIS, ACCOMPANIED BY MICHAEL ROMIG, MANAGER, EMPLOYEE BENEFITS CENTER, AND DAVID E. FRANASIAK, MANAGER, TAX POLICY CENTER, CHAMBER OF COMMERCE OF THE UNITED STATES, WASHINGTON, D.C.

Mr. KELLY. My name is Peter Kelly. I am partner in charge of the employee benefits department of the law firm of Kirkland & Ellis. I am also a member of the Chamber of Commerce Employee Benefits Committee and chairman of that committee's benefits taxation task force.

Accompanying me, on my far left, is Mark Cahoon, associate director of employee benefits and human resources with the chamber, and Dave Franasiak, who is manager, tax policy center, chamber of commerce.

We have prepared a written statement which we have submitted. There are some corrections to that statement which have been given to the staff, including a correction in the table.

I will not go through our comments regarding the health cap in my oral comments but will focus exclusively on fringe benefits. Of course we will take questions on any aspects of the statement.

With respect to fringe benefits, I think there are really two points to make: No. 1, that a continuation of the moratorium is a good thing; and No. 2, we would like to offer some precautions or some areas that you ought to look at in conducting a study during the period of an extended moratorium.

First on the moratorium and why it should be extended:

Not all fringe benefits have the same policy impact or the same potential enforcement or compliance difficulties. Not all fringe benefits have the same potential revenue possibilities or result in disproportionate tax burdens.

We feel that each type of fringe benefit should be addressed separately, in a principled and careful fashion, and we don't believe that the next 6 months allow enough time for that to take place.

We feel the success of this approach is well demonstrated by the history of the moratorium up to date. The initial administrative proposals were back in 1975, and it was intervention of Congress which prevented a subsequent form of those proposals from going into effect.

Basically, we are dealing with an area that did not stay static during that roughly 8 years that Congress has been looking at it. Having a moratorium in effect has permitted Congress, through this committee and the House Ways and Means Committee, to address several aspects of fringe benefits. Examples of those would be dependent care programs, productivity awards, meals and lodging, group legal plans. The point is not so much to reexamine the substance of those issues but to point out that the Congress has a legitimate role to play here and ought to play that role. To force the issue on an across-the-board basis may result in a development of policy that is not tailored to the individual nature of the fringe benefit program.

In reviewing specific fringe benefits, we would urge the committee to resist the efforts of pure advocates of the comprehensive tax base to support inclusion of fringe benefits simply because it advances a perfect definition of what is taxable income.

This idea of a perfect definition of income should not be used to justify impractical or unduly burdensome rules which result in little additional revenues.

In focusing on the specific issues, certain problems will be paramount including the valuation of fringe benefits, withholding or information reporting and the impart of new rules on particular industries.

With respect to valuation, we would suggest that including anything more than the incremental cost to the employer might cause difficulties, significant difficulties. There has been a focus in the past on the difficulties of a market-value approach. We would suggest that focusing on a cost approach as a solution to these difficulties may create additional burdens in allocating overhead expenses to particular fringe benefits.

We would discourage the use of withholding, and we think that you should specifically consider the impact of particular fringe benefits on domestic industries—on manufacturing and service. An example would be company cars with the potential impact on the auto industry; restaurant entertainment, and the potential impact on the restaurant industry. You should also consider the legitimate business objectives that are served by fringe benefit programs. An example of discount sales to employees would be the legitimate objectives of avoiding the negative advertising of having persons identifiable as your employees using competitors' products in their homes.

Finally, we think you should consider that the failure to vigorously tax such benefits reflects a practical compromise between equity objectives, business needs, and limited enforcement resources. And you should consider preserving that balance.

Senator PACKWOOD. Thank you.

[The prepared statement of Peter Kelly follows:]

STATEMENT FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES BY PETER M. KELLY

My name is Peter M. Kelly. I am a partner in the law firm of Kirkland & Ellis. I appear today on behalf of the Chamber of Commerce of the United States where I am a member of the Chamber's Employee Benefits Policy Committee. I also serve as the chairman of that committee's Benefit Taxation Task Force. With me today are Michael J. Romig, Manager of the Chamber's Employee Benefits and Human Resources Policy Center, and David Franasiak, Manager of the Chamber's Tax Policy Center

SUMMARY

We welcome the opportunity to present the Chamber's view in opposition to the Administration's proposal to cap the amount of empolyer provided medical care benefits that may be excluded from an employee's income. We applaud the Finance Committee's decision to begin what we hope will be full and open public debate of the tax policy and tax compliance issues raised by the current law's tax treatment of statutory and non-statutory fringe benefits.

The Chamber is concerned about the implications of the scheduled December 31, 1983, expiration of a Congressionally mandated moratorium on the issuance of Treasury Department regulations governing the tax treatment of employee benefits. The time provided is insufficient to address the many difficult issues presented. We recommend an extension of the moratorium with a commitment for a thorough Congressional review to determine what legislation and/or regulations are needed.

Finally, it is particularly difficult to address the fringe benefit issues in the absence of a specific legislative proposal. Therefore, we will limit our comments to a general discussion of the complex issues presented.

GROUP HEALTH BENEFIT TAX

The Administration has submitted a package of reforms designed to curb health cost inflation. It has proposed revisions to Medicare, Medicaid and private insurance in an effort to slow the rising cost of health care.

For private sector health insurance, the most significant decision would be a limit or cap on how much an employer coud provide in health benefits to an employee before the value of these benefits are included in the taxable income of the empolyee. The Chamber opposes such a tax cap.

Under the Administration proposal, employees would be required to count as income for federal tax purposes the value of such coverage that exceeds $175 a month for a family plan, or $70 a month for an individual plan.

The Department of Health & Human Services argues that federal tax policy has created a bias toward high priced medical coverage instead of higher wages because the former are not subject to income taxes. They add that about 30 percent of those with job related health insurance would be affected and would pay $2.3 billion in additional income taxes in the first year. If these figures are accurate, 23 million employees woud each pay an average of $100 in added taxes.

The idea of a tax cap is not new. The theory behind the cap is that the combination of tax laws and third party insurance arrangements has effectively insulated the consumer from the cost of health care. The remedy, therefore, is to make the user of health care pay for it in a visible manner. To do this, both the tax code and group health insurance would have to be changed.

The tax code has already been changed. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) limited the deductibility of health costs. It eliminated the automatic $150 deduction for health insurance and raised the floor for deductible expenses from 3 percent to 5 percent of adjusted gross income. Since 1983 is the first year for the change, there is no information on the impact on consumers of health care services.

The tax cap is the next step since it would pressure employers and employees to make changes in their group health insurance. We are convinced the idea will not work for the following reasons:

Untested, Unproven.—The proposal to tax health care benefits assumes that individuals will become more cost conscious and, hence, overall health care cost will be reduced. This theory has not been tested, while other ideas, such as statewide payment reform proposals, have been proven effective.

Penalizes Older Workers.—Elderly groups tend to use the health care system more frequently than younger, healthier workers. Hence, the cost of health insurance for a group that includes more than the average number of older workers not only will be higher but could discourage many employers from even hiring older workers. Under the tax cap proposal, these groups would be adversely affected, while younger groups with similar coverage would perhaps not be taxed.

Penalizes Worker in High Risk Occupations.—Some groups, such as iron workers or coal miners, are usually considered a higher risk, and are typically charged higher health insurance premiums. These groups could be unfairly taxed while other groups with similar coverage, such as clerical workers, would be relatively unaffected.

A Form of "Double Taxation".—The Health Insurance Association of America estimates that Medicare and Medicaid payment practices resulted in $5.8 billion being shifted to patients covered by private health insurance in 1982. For the government to shift these costs to the private sector and then tax the resulting higher premium is unfair.

Unfairly Affects Certain Geographic Areas.—The cost of health care is higher in some areas, such as large cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low cost areas. Developing a cap that varied by sex, age or geographic region would be more equitable, but it would be an administrative nightmare and would lead to more bureaucracy and regulation.

A tax cap simply would not generate the expected revenues since "excess" health benefits woud be shifted to other forms of nontaxable compensation.

A tax cap would be another tax at a time when the economic recovery calls for less taxation.

A tax cap would be difficult for employers who self-insure, since they would have to calculate a premium. Once identified, this cost would be the target of state taxation, from which it is currently exempt.

A tax cap could increase health care cost by thwarting competition. Cost effective alternative delivery systems, such as health maintenance organizations (HMO's), would be less attractive, since their premiums tend to be higher than those of traditional health insurance.

In sum, taxing health insurance is an idea we respectfully and vigourously urge this committee to abandon.

EMPLOYEE BENEFITS

Today's employer is spending more than ever before for employee benefits ranging from pensions to coffee breaks. Last year, employers spent a record sum of about $540 billion, up from $435 billion in 1980 and $390 billion in 1979.

Benefits, which equal more than one third of payroll dollars, are growing faster than wages. They rose 161 percent from 1971 to 1981, whereas wages and salaries grew only 115 percent. Inflation, as measured by the consumer price index, was 124 percent during the same period. Benefits rose 8.9 percent from 1980 to 1981, and wages rose 8.5 percent.

Employers spent a weekly average of $127.44 per employee for benefits in 1981 or 37.3 percent of total pay. The comparable figure for 1971 was $48.92 per employee per week or 30.8 percent of average weekly earnings.

Employee benefits in 1981 were analyzed in a survey of 994 manufacturing and nonmanufacturing firms conducted by the Survey Research Center of the U.S. Chamber. This was the 20th benefits study conducted by the Chamber, which has been keeping track of the growth of employee benefits since 1947. Data for 1982 will be published later this year.

The tremendous growth of employee benefits has led some tax policymakers to question current tax policies that give favorable tax treatment to employee benefits. Congress ought not to be pressured by budget deficits into making major changes in the tax code without a full understanding of their implications for the tax payer. Clearly, employee benefits, especially private pensions, have suffered from rapid and sometimes ill-considered changes in tax policy.

For example, not all employee benefits provide income that could be taxed, and not every employee benefit escapes taxation as many people imply. Indeed, most employee benefits are taxed when received or have been specifically excluded from taxation by Congress.

Table 1 shows the benefits surveyed by the U.S. Chamber. We have grouped them by their tax treatment (i.e. taxable, nontaxable by statute, and nontaxable). For each class of benefits, we show their weekly cost in 1971 and 1981, and the percentage change for that period. Table 1 clearly confirms the fact that few employee benefits escape taxation except where Congress has specifically allowed it. It shows that 75 percent of current employee benefits are taxed immediately or taxed at some future time when the employee actually receives the benefit. Another 23 percent of current benefits have been specifically excluded from income tax.

Only 2 percent fall within the group familiarly known as fringe benefits. This amounts to less than 1 percent of pay and is an increase of only 55 percent in the last 10 years. By way of contrast, most of the growth in employee benefits is in taxable benefits (up 155 percent) and statutorily nontaxable benefits (up 201 percent).

Admittedly, data is incomplete. This is one of the problems to be overcome before Congress acts. Nonetheless, it is important not to "tar and feather" all employee benefits as egregious tax loopholes.

ISSUES RELATING TO THE TAXATION OF FRINGE BENEFITS

The definition of what constitutes a fringe benefit is one of the many problems that must be addressed before other related issues can be resolved. Once fringe benefits are defined, policy determinations must be made on the following questions. Which fringe benefits should be taxed? How are benefits to be valued for tax purposes? How are benefits to be allocated among employees? Should fringe benefits be reported as is done with wages? Should taxes be withheld? What other considerations should be permitted in determining taxation?

Our recent history suggests answers to these and many other questions are not easy. We specifically caution against the disallowance, in whole or part, of the employer's deduction for providing fringe benefits, or the imposition of an excise tax on employers.

We applaud the Committee on Finance for beginning what we hope will prove to be an open and comprehensive congressional review so that satisfactory decisions can be reached. Workable solutions can be reached, but they will require substantial study of a wide range of matters. This will require considerable time. We suggest that it may be necessary to extend the current moratorium until this review has been completed by Congress.

CONCLUSION

The Chamber is opposed to the proposed tax cap on group health insurance. Whatever is done with fringe benefits should be the product of a comprehensive and open review of all aspects of this complex matter.

TABLE 1.—WEEKLY EMPLOYEE BENEFITS, PER EMPLOYEE,[1] GROUPED BY TAX TREATMENT

	1971	1981	Percent change
I. Taxable benefits [2] (75 percent of total in 1981):			
Old age, survivors, disability and health insurance (FICA taxes)	$7.15	$21.60	+202
Private pensions	7.73	17.88	+131
Paid vacation	7.69	16.96	+121
Paid rest periods, coffee breaks, lunch periods, et cetera	5.38	11.46	+113
Paid holidays	4.69	11.48	+145
Paid sick leave	1.56	4.60	+195
Unemployment compensation	1.15	4.25	+270
Profit-sharing payments	1.65	3.69	+124
Short-term disability	([3])	1.23	([3])
Thrift plans	0.31	1.23	+297
Salary continuation or long-term disability	([3])	0.79	([3])
Subtotal	37.31	95.17	+155
II. Statutorily nontaxable benefits (23 percent of total in 1981):			
Insurance (life, hospital, surgical, medical, et cetera)	7.10	20.63	+191
Workers' compensation	1.58	4.94	+213
Dental insurance	([3])	1.29	([3])
Christmas or other special bonuses, suggestion awards, etc	.67	1.17	+75
Employee education expenditures	.15	.77	+413
Employee meals furnished free	.25	.58	+132
Subtotal	9.75	29.38	+201
III. Nontaxable fringe benefits (2 percent of total in 1981):			
Discounts on goods and services purchased from company by employees	.23	.48	+109
Other employee benefits	1.63	2.41	+48
Subtotal	1.86	2.89	+55
Average weekly earnings	158.85	342.04	+115

[1] The data presented are from the Chamber's Annual Employee Benefit Survey. Not all employee fringe benefits are included.

[2] Tax treatment varies.

[3] Not available.

Chamber of Commerce of the United States
1615 H Street, N.W.
Washington, D.C. 20062

NEWS RELEASE

FOR AFTERNOON RELEASE
Wednesday, June 22, 1983

Contact: Frank Benson
(202) 463-5682

ADMINISTRATION'S TAX CAP PROPOSAL ON MEDICAL CARE BENEFITS DRAWS CHAMBER OPPOSITION AT SENATE HEARING

WASHINGTON, June 22 -- An Administration plan to require workers to pay income taxes on medical care benefits provided by employers above a certain dollar limit drew the solid opposition today by the U.S. Chamber of Commerce, in testimony scheduled before the Senate Finance Committee.

The proposal to count as income for tax purposes the value of medical coverage exceeding $175 a month for a family plan -- $70 a month for an individual plan -- "is an idea we vigorously urge you to abandon," said Peter M. Kelly, testifying on behalf of the Chamber. Kelly, partner in the law firm of Kirkland & Ellis, testified for the Chamber in his role as a member of the business federation's Employee Benefits Policy Committee as well as chairman of that group's Benefit Taxation Task Force.

Instead of moving ahead on the new tax proposal, the Chamber called on Congress to extend an earlier moratorium on the issurance of regulations by the Treasury Department covering tax treatment of employee benefits. After extending the moratorium, now scheduled to expire the end of this year, the business group called for a Congressional review "to determine what legislation and/or regulations are needed" pertaining to employee benefits.

The Chamber hailed the Finance Committee's decision "to begin what we hope will be full and open public debate of the tax policy and tax compliance issues raised by the current law's tax treatment of statutory and non-statutory fringe benefits." At the same time, the business spokesman cautioned lawmakers "not to be pressured by budget deficits into making major changes in the tax code without a full understanding of their implications for the taxpayer."

Kelly pointed out that few employee benefits now escape taxation except where Congress has specifically provided for such exemption. In fact, he said, 65 percent of current employee benefits are taxed either immediately or at some future time on receipt of the benefits, and another 25 percent of current benefits are specifically excluded from income tax.

The Chamber cited a variety of objections to the plan to cap health care benefits, starting with the fact that the theory behind such a proposal -- an eventual reduction in health care cost -- is untested and unproven. In addition, the business organization told the lawmakers, it penalizes older workers because the health care costs for such employees runs higher than individual costs for younger workers.

Such a plan would also penalize workers in high risk occupations, where health insurance premiums are usually higher, as well as employees in geographical areas where the cost of health care is higher and requires larger employer-paid benefits, the Chamber added. Furthermore, Kelly noted, the tax cap "will not generate the expend revenues" its proponents envision, "since 'excess' health benefits will be shifted to other forms of non-taxable compensation."

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NOTE TO CORRESPONDENTS: A complete copy of the statement is available from the Chamber News Department, 463-5682.

STATEMENT OF JOHN D. BLOSSOM, JR., M.S.P.A., PRESIDENT, RETIREMENT ADMINISTRATORS AND DESIGNERS OF AMERICA, PEORIA, ILL.

Mr. BLOSSOM. My name is John Blossom. I am president of Small, Parker, Ackerman, Blossom, a benefits consulting and actuarial firm from Peoria, Ill. I also serve as president of RADA, Retirement Administrators and Designers of America, and am submitting testimony on behalf of our 25 offices located across the country from Miami, Fla. to San Francisco, Calif.

Senator PACKWOOD. Let me ask you a question. What is a retirement designer? Do you design retirement homes? Or retirement packages? Or what?

Mr. BLOSSOM. The organization RADA is a network of consulting and actuarial firms; we do the consulting work, the design of plans, and the administration of plans—medical benefit plans and pension plans.

Senator PACKWOOD. Thank you.

Mr. BLOSSOM. We urge you to not recommend the implementation of the proposed health benefits cap tax. Such a tax would create a serious problem of discrimination which would produce very negative results.

We strongly oppose a medical benefits tax because it will create unfavorable discrimination in four distinct ways:

First, discrimination against older employees.

Since the cost of medical care escalates significantly as persons grow older, the cost of a self-funded plan or the premium that is charged by an insurance company is higher for older plan participants than it is for younger. This will create the very undesirable result of the tax being much more likely to be paid by an employee of a company that hires many older workers than one which hires younger persons. This will create an unfair burden on older persons and make them less attractive as employees.

Second, the tax would create discrimination against certain geographic areas.

The cost of medical care and therefore the cost of medical benefits varies widely across the country and from community to community. There are a variety of factors which affect medical care costs—supply of physicians and other medical personnel, availability or lack thereof of alternative care resources, the availability of high technology medical equipment, extent of community services provided by the medical center, involvement or commitment to medical teaching facilities and staff, and, finally, availability of specialty medical treatment.

Since these factors differ widely from one community to another, the location at which a person is employed would affect the likelihood of an employee reaching a tax threshhold that might be established through a health benefits tax. This would produce the very undesirable effect of a tax which would be highly influenced by a person's choice of geographic residence.

Third, such a tax would discriminate against unfortunate persons. Medical benefit costs paid for in the form of premiums by smaller companies are highly affected by the medical claims experience of that employee group. Therefore, if a small group experiences even a single catastrophic loss, that group's rates will normally be increased at renewal time, and that will result in employees who are struck by a major illness, and their fellow workers, being much more likely to reach the tax threshhold than other persons.

Fourth, such a program would create discrimination against small business. The cost per employee of providing medical benefits is significantly higher for an organization which employs fewer than less than 100 employees than similar benefits cost at larger companies.

Benefit technology such as self-funding of claims and health risk management programs are not normally feasible in the less-than-100-employee company.

In addition, the marketing and distribution system for medical benefits creates significantly greater expense per covered employee in the small employer organization than for the large employer who can spread those costs over a much larger number of participants. As a result, a medical benefits cap tax would impact much more heavily on the employee of the small employer than his counterpart with equal benefits at a large company.

It appears to us that the proposed tax will impact far more plans than those which are near the tax threshhold in June of 1983. The impact of the major cost shifting that is about to occur from the medicare system to the private sector hasn't reached the medical benefits pricing system yet. The effect of the Tax Equity and Fiscal Responsibility Act, making medicare the secondary payor for workers 65 to 69, will increase the cost of medical benefits for all employees as that cost increase is spread over the workforce. The October 1, 1983, implementation of prospective reimbursement for medicare will result in revenue loss to many medical care providers, and that will most likely result in increased costs to other public and private purchasers of the care.

To assume that a new and discriminatory tax on employee participants in medical benefit plans is necessary for health care cost-containment is to virtually ignore the strong, natural employer motivation to control and reduce costs wherever possible.

Finally, the implementation of the Health Care Cost-Containment Act of 1983, or any similar proposal, will add another level of administrative and compliance costs for employers to absorb. Employers are already struggling with an immense burden of Government compliance activities.

In summary, if the objective of the Health Care Cost-Containment Act of 1983 is to raise tax dollars for Government spending, it may be that it would reach that end. However, the result would come at the expense of those on whom this highly discriminatory tax act would impact most—older employees, certain geographic areas, unfortunate persons, and employees of small companies.

The net result of the act would be, in our opinion, very little impact if any on the cost of health care services.

We thank you for the opportunity to testify and stand ready to help in any way we can as you consider this important question.

Senator PACKWOOD. Thank you.

[The prepared statement of John Blossom, Jr., follows:]

STATEMENT OF SMALL/PARKER/ACKERMAN/BLOSSOM, INC. BY JOHN BLOSSOM

Thank you for the opportunity to present information for your consideration as you deliberate the prospective Health Benefits Cap Tax.

My name is John Blossom—I am President of Small/Parker/Ackerman/Blossom, Inc.—a benefits consulting and actuarial firm from Peoria, Illinois. Our firm serves over 300 corporate employers located primarily in Central Illinois. We are active members of the Society of Professional Benefit Administrators and the International Foundation for Employee Benefits. My testimony is given on behalf of the employers we serve and the participants in their group benefit plans.

I also serve as President of "RADA"—Retirement Administrators and Designers of America and am submitting testimony on behalf of our twenty five offices located across the country from Miami, Florida to San Francisco, California. Our network of offices serves over 5,000 employers with their benefit plan consulting and administration needs.

We urge you to not recommend the implementation of the proposed Health Benefits Cap Tax. Such a tax would create a serious problem of discrimination which would produce very negative results. We strongly oppose a Medical Benefits tax because it will create unfavorable discrimination in the following ways.

1. Discrimination against older employees—Since the cost of medical care escalates significantly as persons grow older, the cost in a self-funded plan, or premium charged by an insurance company, is higher for older plan participants than younger. This will create the very undesirable result of the tax being much more likely to be paid by an employee of a company that hires older employees than one which hires younger persons. This will create an unfair burden on older persons and make them less attractive as employees.

2. Discrimination against certain geographic areas—The cost of medical care, and therefore, the cost of medical benefits varies widely across the country—and from community to community. The following factors affect medical care costs dramatically: Supply of physicians and other medical personnel; Availability (or lack thereof) of alternative care resources; Availability of high technology medical equipment; Extent of community services provided by the medical center; Involvement or commitment to medical teaching facilities and staff; and Availability of specialty medical treatment.

Since these factors differ from one community to another, the location at which a person is employed would affect the likelihood of an employee reaching the "tax-threshold" of the Health Benfits Cap Tax. This would produce the undesirable effect of a tax which would fall on persons who would be highly influenced by their choice of geographic residence.

3. Discrimination against unfortunate persons—Medical benefit costs, paid in the form of premiums by smaller companies, are highly affected by the medical claims experience of the employee group. Therefore, if a small group experiences even a single catastrophic loss, its rates will normally be increased at renewal time. This will result in employees who are struck by a major illness, and their fellow workers, being more likely to reach the "tax-threshold" than other persons.

4. Discrimination against small business—The cost per employee of providing medical benefits is significantly higher for an organization which employs fewer than 100 employees than similar benefits cost a very large employer. Benefit technologies such as self-funding of claims and health risk management programs are not normally feasible in the under 100 employee company. In addition, the marketing and distribution system for medical benefits creates significantly greater expense per employee in the small employer organization than for the large employer who can spread those costs over a much larger number of participants. The Medical Benefits Cap Tax would impact more heavily on the employees of the small employers than his counterpart with equal benefits at a large company.

The proposed tax will impact for more plans than those which are near the "tax-threshold" in June of 1983. The impact of major cost shifting from the Medicare system to the private sector has not reached the medical benefits pricing system yet. The effect of the Tax Equity and Fiscal Responsibility Act making Medicare the secondary payor for workers age 65–69 will increase the cost of medical benefits for all employees as that cost increase is spread over the work force. The October 1, 1983 implementation of prospective reimbursement for Medicare will result in revenue loss to many medical care providers which will most likely result in increased cost to other public and private purchasers of care.

All employers are dramatically aware of the skyrocketing cost of medical benefits. They are painfully aware of the situation because of its impact on costs and profitability. Most employers are developing more cost effective medical benefit programs and more effective health care delivery and financing systems are emerging rapidly. To assume that a new—and discriminatory—tax on employee participants in plans is necessary for "Health Care Cost Containment" is to ignore the strong, natural employer motivation to control and reduce costs wherever possible. Finally, the implementation of the "Health Care Cost Containment Act of 1983," or any similar proposal, will add another level of administrative and compliance costs for employers to absorb. Employers are already struggling with an immense burden of government compliance activities.

If the objective of the "Health Care Cost Containment Act of 1983" is to raise tax dollars for government spending there is little doubt that it would succeed. However that success would come at the expense of those on whom this highly discriminatory tax would impact: Older employees; Certain geographic areas; Unfortunate persons; and Employees of small companies.

And the net result of the Act would be very little impact, if any, on the cost of health care benefits for employees—while adding administrative and compliance costs for employers and the federal government.

EXHIBIT A

TYPICAL SMALL EMPLOYER
$100 Deductible-Medical Plan Costs

Geographic Area 2

Mutual Benefit Life
Newark, NJ & Kansas City, MO

THE CHARTER SERIES

AREA 2
3-9 LIVES*
PLAN IIM

COMPREHENSIVE MAJOR MEDICAL MONTHLY PREMIUMS

EFFECTIVE JANUARY 2, 1983

AREA 2
3-9 LIVES*
PLAN IIM

OFFICERS AND EMPLOYERS, AND EMPLOYEES EARNING $1,250 OR MORE PER MONTH

	MALE EMPLOYEE				FEMALE EMPLOYEE				
EMPLOYEE AGE**	EMPLOYEE	ADDITIONAL PREMIUM FOR			EMPLOYEE	ADDITIONAL PREMIUM FOR			EMPLOYEE AGE**
		SPOUSE	CHILD(REN)	SPOUSE & CHILD(REN)		SPOUSE	CHILD(REN)	SPOUSE & CHILD(REN)	
UNDER 30	32.66	106.95	46.21	147.59	62.38	49.61	46.21	90.25	UNDER 30
30-34	39.24	86.39	51.91	132.73	63.74	56.66	51.91	103.00	30-34
35-39	44.86	72.12	56.17	122.72	61.69	62.21	56.17	112.81	35-39
40-44	59.44	81.44	60.35	136.22	73.96	76.48	60.35	131.26	40-44
45-49	75.15	91.89	56.17	142.49	87.26	91.89	56.17	142.49	45-49
50-54	93.67	105.13	51.91	151.47	100.31	105.13	51.91	151.47	50-54
55-59	115.05	121.19	43.48	159.10	116.08	121.19	43.48	159.10	55-59
60-64	148.68	149.28	30.90	174.61	143.78	149.28	30.90	174.61	60-64
65-69	42.91	43.75	29.54	67.72	41.62	43.75	29.54	67.72	65-69
70 & OVER	51.07	52.05	29.54	76.02	49.52	52.05	29.54	76.02	70 & OVER

NOTE: IF EMPLOYEE IS UNDER 65 AND SPOUSE IS 65 OR OVER (1) THE "SPOUSE" PREMIUM IS $43.75
AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $38.18.
IF EMPLOYEE IS 65 OR OVER AND SPOUSE IS UNDER 65 (1) THE "SPOUSE" PREMIUM IS $149.28
AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $143.71.

ALL OTHERS EARNING LESS THAN $1,250 PER MONTH

	MALE EMPLOYEE				FEMALE EMPLOYEE				
EMPLOYEE AGE**	EMPLOYEE	SPOUSE	CHILD(REN)	SPOUSE & CHILD(REN)	EMPLOYEE	SPOUSE	CHILD(REN)	SPOUSE & CHILD(REN)	EMPLOYEE AGE**
UNDER 30	29.76	96.09	41.86	132.38	61.65	44.89	41.86	81.18	UNDER 30
30-34	35.63	77.73	46.95	119.11	57.51	51.19	46.95	92.57	30-34
35-39	40.66	64.99	50.75	110.17	55.68	56.14	50.75	101.32	35-39
40-44	53.67	73.31	54.48	122.22	66.63	68.89	54.48	117.80	40-44
45-49	67.69	82.64	50.75	127.82	78.51	82.64	50.75	127.82	45-49
50-54	84.23	94.47	46.95	135.85	90.16	94.47	46.95	135.85	50-54
55-59	103.32	108.80	39.42	142.65	104.23	108.80	39.42	142.65	55-59
60-64	133.35	133.88	28.18	156.49	128.98	133.88	28.18	156.49	60-64
65-69	40.80	41.59	28.18	64.20	39.58	41.59	28.18	64.20	65-69
70 & OVER	48.50	49.42	28.18	72.03	47.03	49.42	28.18	72.03	70 & OVER

NOTE: IF EMPLOYEE IS UNDER 65 AND SPOUSE IS 65 OR OVER (1) THE "SPOUSE" PREMIUM IS $41.59
AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $36.02.
IF EMPLOYEE IS 65 OR OVER AND SPOUSE IS UNDER 65 (1) THE "SPOUSE" PREMIUM IS $133.88
AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $128.31.

*DISCOUNTS FOR LARGER GROUPS

NUMBER OF EMPLOYEES INSURED	MULTIPLY ABOVE PREMIUMS BY
10 - 24	.94
25 - 50	.89

THE ACTUAL DISCOUNTED PREMIUMS MAY DIFFER BY A FEW CENTS, DUE TO ROUNDING

**PREMIUM WILL CHANGE ON FIRST OF MONTH IN WHICH EMPLOYEE ENTERS HIGHER AGE BRACKET

2444GD
11011

EXHIBIT B

Mutual Benefit Life
Newark, NJ & Kansas City, MO

THE CHARTER SERIES

TYPICAL SMALL EMPLOYER
$100 Deductible-Medical Plan Costs

Geographic Area 6

AREA 6
3-9 LIVES*
PLAN IIM

COMPREHENSIVE MAJOR MEDICAL MONTHLY PREMIUMS

EFFECTIVE JANUARY 2, 1983

AREA 6
3-9 LIVES*
PLAN IIM

	MALE EMPLOYEE				FEMALE EMPLOYEE				
EMPLOYEE AGE**	EMPLOYEE	ADDITIONAL PREMIUM FOR			EMPLOYEE	ADDITIONAL PREMIUM FOR			EMPLOYEE AGE**
		SPOUSE	CHILD(REN)	SPOUSE & CHILD(REN)		SPOUSE	CHILD(REN)	SPOUSE & CHILD(REN)	
OFFICERS AND EMPLOYERS, AND EMPLOYEES EARNING $1,250 OR MORE PER MONTH									
UNDER 30	44.94	152.91	64.64	211.98	96.85	69.57	64.64	128.64	UNDER 30
30-34	54.50	123.03	72.92	190.38	90.11	79.82	72.92	147.17	30-34
35-39	62.68	102.29	79.11	175.83	87.13	87.89	79.11	161.43	35-39
40-44	83.86	115.83	85.18	195.44	104.96	108.63	85.18	188.24	40-44
45-49	106.69	131.02	79.11	204.56	124.29	131.02	79.11	204.56	45-49
50-54	133.61	150.27	72.92	217.62	143.26	150.27	72.92	217.62	50-54
55-59	164.68	173.60	60.67	228.70	166.17	173.60	60.67	228.70	55-59
60-64	213.55	214.42	42.38	251.23	206.44	214.42	42.38	251.23	60-64
65-69	59.84	61.05	40.41	95.89	57.97	61.05	40.41	95.89	65-69
70 & OVER	71.70	73.12	40.41	107.96	69.44	73.12	40.41	107.96	70 & OVER

NOTE: IF EMPLOYEE IS UNDER 65 AND SPOUSE IS 65 OR OVER (1) THE "SPOUSE" PREMIUM IS $61.05 AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $55.48. IF EMPLOYEE IS 65 OR OVER AND SPOUSE IS UNDER 65 (1) THE "SPOUSE" PREMIUM IS $214.42 AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $208.85.

	MALE EMPLOYEE				FEMALE EMPLOYEE				
ALL OTHERS EARNING LESS THAN $1,250 PER MONTH									
UNDER 30	40.72	137.12	58.30	189.85	87.07	62.72	58.30	115.45	UNDER 30
30-34	49.26	110.44	65.71	170.58	81.05	71.86	65.71	132.00	30-34
35-39	56.56	91.92	71.23	157.58	78.39	79.07	71.23	144.73	35-39
40-44	75.47	104.02	76.65	175.10	94.31	97.59	76.65	168.67	40-44
45-49	95.85	117.58	71.23	183.24	111.57	117.58	71.23	183.24	45-49
50-54	119.89	134.77	65.71	194.91	128.51	134.77	65.71	194.91	50-54
55-59	147.63	155.60	54.76	204.79	148.96	155.60	54.76	204.79	55-59
60-64	191.27	192.05	38.43	224.91	184.92	192.05	38.43	224.91	60-64
65-69	56.77	57.91	38.43	90.77	55.00	57.91	38.43	90.77	65-69
70 & OVER	67.96	69.29	38.43	102.15	65.83	69.29	38.43	102.15	70 & OVER

NOTE: IF EMPLOYEE IS UNDER 65 AND SPOUSE IS 65 OR OVER (1) THE "SPOUSE" PREMIUM IS $57.91 AND (2) THE "SPOUSE & CHILD(REN)" PREKIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $52.34. IF EMPLOYEE IS 65 OR OVER AND SPOUSE IS UNDER 65 (1) THE "SPOUSE" PREMIUM IS $192.05 AND (2) THE "SPOUSE & CHILD(REN)" PREMIUM IS THE SUM OF THE "CHILD(REN)" PREMIUM AND $186.48.

*DISCOUNTS FOR LARGER GROUPS

NUMBER OF EMPLOYEES INSURED	MULTIPLY ABOVE PREMIUMS BY
10 - 24	.94
25 - 50	.89

THE ACTUAL DISCOUNTED PREMIUMS MAY DIFFER BY A FEW CENTS, DUE TO ROUNDING

**PREMIUM WILL CHANGE ON FIRST OF MONTH IN WHICH EMPLOYEE ENTERS HIGHER AGE BRACKET

24486D
11027

STATEMENT OF PAUL R. HUARD, VICE PRESIDENT, TAXATION AND FISCAL POLICY DEPARTMENT, NATIONAL ASSOCIATION OF MANUFACTURERS, WASHINGTON, D.C.

Mr. HUARD. Thank you, Senator.

I am Paul Huard, vice president of taxation and fiscal policy for the National Association of Manufacturers. I am accompanied this afternoon by A. Dale Stratton, assistant director for compensation and benefits of the Du Pont Co., and a member of the health care subcommittee of the employee benefits committee of the association.

NAM opposes any proposal to cap the amount of employer-paid health benefits which may be excluded from employee income. Let me summarize our objections, generally, to this proposal.

The tax cap has been put forth as a health care cost containment measure and also as a revenue raising device. I think commonsense tells us that it could not do both well, simultaneously. Either it will be effective in raising revenue, which means it hasn't been very effective in keeping down the cost of health care; or, if it depresses the cost of health care, it won't be that effective in raising revenue.

In addition, as has already been pointed out, I am not too sure how heavily we want to rely on the Government's ability to predict what it is going to raise in any case.

We think that the tax cap would be unfair in many respects—this has also been pointed out. It would discriminate against employees or classes of employees on the basis of age, geographic location, or health status. We think that the tax cap would adversely affect labor costs and collective bargaining.

Faced with increased income taxes or, alternatively, with reductions in employer-paid benefits, employees quite naturally will seek either increased wages or other fringe benefits which may be nontaxable. This pressure will apply in all cases but will be particularly keen where the labor force is unionized.

We think the tax cap may discourage the use of HMO's. Many HMO premiums tend to be relatively high compared to insured plan payments because of the comprehensive coverage they provide. They would probably exceed the cap in more cases than the insured plan would. We don't think this is a particularly good idea because I think HMO type of care, which emphasizes comprehensive coverage including preventive care, tends to hold down hospital utilization. So we don't think it is advisable to discourage HMO utilization.

Finally, as has also been noted, we object to the double-taxation effect, where you have the medicare shift into the private sector and then the resulting higher premiums from the private insurers are then factored into this tax cap system, and they get taxed again.

Let me turn now to the subject of other fringe benefits. As you know, since 1977 there has been a moratorium on the adoption of any new Treasury regulations in the employee fringe benefit area. This moratorium has been extended several times and is currently scheduled to expire at the end of this year. NAM urges that it be extended once again.

This moratorium was imposed and has been continued in effect as a congressional reaction to attempts by the Treasury to expand the spectrum of taxable fringe benefits. The last time the fringe benefit moratorium was extended, Congress explicitly recognized that any significant tax policy changes in the longstanding treatment of fringe benefits should not be done administratively by the Treasury but should be done legislatively by the Congress itself.

NAM endorses the view that a legislative rather than an administrative approach is what is required. However, since we are not aware of any substantive activity by the Congress in this area since the last extension of the fringe benefit moratorium, and because of the many complex issues involved, we do not think that the remaining six months of the moratorium really provides sufficient time for the review and evaluation of these complex issues. We therefore recommend that the moratorium be extended for a minimum of two more years or until at least the end of 1985.

Should the Congress turn to a comprehensive revision of the treatment of the so-called nonstatutory employee fringe benefits, we recommend that the following points be given serious consideration:

We think every effort should be made to come up with a system that minimizes the cost of administration to the employer. This is particularly acute in the case of the small employers who just don't have batteries of accountants and attorneys to interpret and apply complex reporting systems.

Generally speaking, as to valuation problems, there is probably no valuation technique which will work well in every single instance, but we believe generally that valuation should be on the basis of the lowering of costs, incremental costs to the employer, or fair market value.

With regard to the incidence of taxation, we think in cases where it is decided that a particular fringe benefit should be taxable, the taxable entity should be the recipient of the benefit.

We would strongly oppose any technique which involved the denial of employer deductions or the assessment of some kind of excise tax on the employer on the aggregate value of fringes provided, either in the aggregate or in excess of a certain floor or ceiling.

Finally, we agree with the prior statement of the American Bar Association that there should be an understandable pattern of exclusions. While I wouldn't necessarily agree with all of the criteria that the ABA witness set forth, we do agree that there should be some kind of de minimus rule where you just don't tax fringes that are relatively insubstantial in amount, and that there should be a rule excluding the taxation of what amount to working conditions like the provision of security guards, or, as you pointed out, the lunches when you are 50 miles up the hill.

And also there should be, finally, an exclusion for the type of benefits that are provided in the course of an employer's trade or business, such as the airline passes that were mentioned.

Thank you very much.

[The prepared statement of Paul Huard follows:]

STATEMENT OF PAUL R. HUARD ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

I am Paul R. Huard, Vice President for Taxation and Fiscal Policy of the National Association of Manufacturers. I am accompanied this afternoon by A. Dale Stratton, Assistant Director for Compensation and Benefits of the E.I. du Pont de Nemours Company, representing NAM's Employee Benefit Committee. On behalf of the Association's 13,000 member firms who represent 85 percent of the nation's industrial output and 80 percent of its industrial workforce, we are pleased to be here to present our position on the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from employee income. I will also take this opportunity to express our views on the general subject of changing the ways in which employee fringe benefits traditionally have been taxed.

A key focus of today's hearing is health insurance, the portion of employee benefits that is constantly demanding an increasing share of corporate resources. For example, a recent survey of approximately 520 manufacturing companies reported that the average 1981 payment for employee health insurance was $1,140—almost double the 1975 payment of $585.

As proposed by the Administration (and introduced as S. 640), the current tax-free status of employer-provided health benefits would be changed. Under the proposal, employees would be required to include as income for federal tax purposes all health plan premium costs above $175 per month for a family and $70 a month for an individual. These limits would be indexed for inflation. It is estimated by the Department of Health and Human Services that 30 percent of those with employer-paid health insurance would be affected by this bill.

NAM opposes limiting the amount of benefits that are tax exempt to the employee for a variety of reasons. Among other things, the tax cap would tend to:

Result in a Double Tax on the Private Sector.—Medicare and Medicaid payment practices now cause cost shifting to private payers of insurance. (It is estimated that $5.8 billion was cost-shifted in this way in 1982.) Shifting these costs and then taxing the higher insurance premiums would create an extra burden for employees.

Shift Labor Costs.—Faced with an increase in tax liability or, alternatively, with a reduction in the amount of employer-paid insurance, workers may seek increased wages or other non-taxable fringe benefits. The latter may well mean no increase in tax revenues.

Impact Collective Bargaining Agreements.—The employer's flexibility to negotiate on health benefits would be reduced as a result of a tax cap, as labor would make efforts to counteract the impact on worker tax liability. Employers may be pressured to reopen collective barganing agreements.

Ignore Other Causes of Health Costs.—Supporters of the tax cap contend it will encourage employers to limit the amount of insurance offered to employees and make the latter more cost-conscious. Many companies are already implementing health care cost-saving measures, and the tax cap may discourage such initiatives. Savings from this proposal may prove to be illusory at best.

In addition to the foregoing problems, a change in the tax status of employee health insurance may discourage the use of Health Maintenance Organizations (HMOs). Because of their comprehensive benefit coverage, HMO premiums are often higher than health plans covering fee-for-service care. Many HMO premiums would exceed the caps proposed by the Administration. HMOs, however, have provided costs savings in many cases because of their tendency to hold down hospital utilization, and this should not be discouraged.

Certain geographic areas would be more adversely affected by the tax cap than others. In general, major metropolitan areas have higher health care costs than do other sections of the country. The uniform cap proposed by the Administration would penalize high cost areas and encourage more generous plans in low-cost areas. On the other hand, varying the cap across the country would pose complex administrative problems.

The tax cap proposal also discriminates against elderly workers. Older workers tend to use the health care system more frequently than younger individuals. In addition, employer health plans—rather than Medicare—are now considered primary for workers 65 to 69 under regulations implementing the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Groups which include a significant number of older workers thus would have higher insurance costs than groups with younger employees, with the result that the former would be more adversely affected by the tax cap than the latter.

Supporters of a health care tax cap have offered the proposal as a cost control measure, and at the same time have touted it as a revenue raiser. But common sense should tell us it cannot be both of these things simultaneously, since its effectiveness as a revenue raiser would be a clear indication of its ineffectiveness as a cost control measure.

The Administration estimates that its tax cap proposal will yield $2.3 billion in FY 1984. This estimate makes certain assumptions about expected changes in employer-employee behavior and also about the government's ability to accurately predict health care program costs. Experience with such programs as Social Security and Medicare, however, is not such as to inspire confidence in the accuracy of government predictions of either revenues or outlays.

The suggestion that the health care tax cap will bring much needed revenue to a deficit-plagued federal budget thus may raise false hopes. Projected revenues from the tax cap have been linked by some to the provision of health insurance for the unemployed and catastrophic health insurance for the elderly. But these projections are questionable, and it would be unwise to base funding for a health insurance program for the unemployed and/or catastrophic health protection for the elderly on such highly speculative revenues.

What will be the impact of the proposed tax cap on a typical manufacturing company and its employees? To answer this question, we took a look at a unionized NAM member in the Midwest with 50,000 employees. That company would be affected in the following way:

	Estimated 1984 premium	Minus tax cap	Equals taxable amount	Additional annual tax
Hourly paid	$3,504	$2,100	$1,404	[1] $421
Management	4,032	2,100	1,932	[2] 772

[1] Assumes 30 percent marginal tax rate.

[2] Assumes 40 percent tax marginal rate.

As the data show, the estimated 1984 premium for the hourly employee is $292 monthly, so that worker would pay $421 in additional tax if the cap is set at $175 a month. For the management employee, the monthly premium is $336 and the additional tax would amount to $772. This particular company has been experiencing 16 percent annual premium increases so that if present trends continue, the management employee could be paying $2,803 in additional income tax by 1990. (See the chart below, which assumes a 6 percent annual increase in the tax cap.)

	Monthly premium	Minus tax cap	Equals taxable amount	Annualized	Additional annual tax [1]
1985	$390	$175	$215	$2,580	$1,032
1986	452	185	267	3,204	1,281
1987	524	196	328	3,936	1,574
1088	607	207	400	4,800	1,920
1989	704	219	485	5,820	2,328
1990	816	232	584	7,008	2,803

[1] Assumes 40 percent marginal rate.

For all of the reasons described above, the NAM strongly opposes any proposal to cap the amount of employer-provided medical care that may be excluded from employee income. A resolution recently adopted by the Association's policy subcommittee on health care and its employee benefits steering group summarizes our position: "The National Association of Manufacturers believes that any change in the tax exempt status of employee health benefit plans would be inequitable because of variations in medical costs relative to geographic locations, age group, and health status, and such a change could discourage cost containment initiatives already underway. In the short run, a tax cap on health benefits would be ineffective in slowing the rising costs of health care, and may be ineffective in the long run as well. We urge the Congress to reject any attempt to change the tax status of employee health benefits."

Let me turn now to the subject of other (i.e., non-health care) fringe benefits. As you know, there has since 1977 been a moratorium on the adoption of any new Treasury regulations in the employee fringe benefit area. This moratorium has been extended several times and is currently scheduled to expire on December 31, 1983. NAM urges that it be extended once again.

The fringe benefit moratorium was imposed, and has been continued in effect, as a Congressional reaction to attempts by the Treasury Department to expand the spectrum of taxable fringe benefits. Although ostensibly the moratorium applies only to the issuance of regulations, its intent is that neither Treasury nor the IRS will in any way, whether through regulations, revenue rulings, revenue procedures, etc., change the historical (i.e., pre-1977) treatment of traditional fringe benefits. (See General Explanation of the Economic Recovery Tax Act of 1981, P.L. 97-34, prepared by Joint Committee on Taxation, at 357.) Moreover, the last time the fringe benefit moratorium was extended, Congress explicitly recognized that any significant tax policy changes in the long-standing treatment of fringe benefits should not be done administratively by the Treasury, but instead should be done legislatively by the Congress itself. (See General Explanation of the Economic Recovery Tax Act of 1981, P.L. 97-34, prepared by Joint Committee on Taxation, at 356.)

NAM endorses the view that a legislative rather than an administrative approach is what is required. However, we are not aware of any substantive activity by the Congress in this area since the last extension of the fringe benefit moratorium was adopted in 1981. Because of the many complex issues involved, we do not think that the remaining six months of the moratorium will provide sufficient time for the Congress to review and evaluate such issues and then prepare and adopt a legislative resolution that is comprehensive, fair and workable. Therefore, it is our recommendation that the moratorium be extended for a minimum of two more years, until at least December 31, 1985.

Should the Congress attempt a comprehensive revision of the current tax treatment of employee fringe benefits, we recommend that the following points be given serious consideration:

(1) *Administrative Burdens.*—As a practical matter, the administrative burden involved in the valuation and reporting of employee fringe benefits necessarily falls upon the employer. As an association of some 13,000 employers, the vast majority of whom are small businesses, we firmly belived that any new approach to the taxation of fringe benefits must attempt to achieve both simplification and the minimization of administrative costs. Simplicity is required to assure proper implementation—particularly by small employers who often lack the resources to handle complex reporting requirements—as well as to facilitate understanding by employees. The employer's administrative costs are a non-productive expense which in most cases will be passed on to customers through price increases, an undesirable result which adds to inflation and detracts from the competitiveness of the employer's products. Such costs are also deductible business expenses and as such will to a greater or lesser degree offset the Treasury's revenue gain from increased taxes on employees. Obviously, such administrative costs should be kept as low as possible.

(2) *Valuation Problems.*—It is probably fair to say that no single technique of valuing employee fringe benefits will work either well or fairly in all cases. We believe, however, that the adherence to the following guidelines will produce the best overall results: (a) The income imputed to the employee receiving a fringe benefit from an employer should in no case be greater that the lower of (i) the fair market value of the benefit received or (ii) the cost to the employer of providing the benefit. (b) In determing the cost to the employer of providing a particular fringe benefit, incremental rather than allocated cost should be used. (c) There should be some sort of "de minimis" rule which excludes from taxation those employee fringe benefits which are of minor consequence whether on a per employee or a per incident basis. In the case of such benefits, failure to provide a "de minimis" exception could easily result in the revenue loss from the employer's tax-deductible administrative costs exceeding the revenue gain from inclusion of the benefits in employee taxable income.

(3) *Taxable Entity.*—Under any revision of the rules for taxing (or not taxing) employee fringe benefits, the employee should be the taxable entity in any case where it is decided to impose a tax. NAM would strongly oppose any scheme which attempted to limit or contain fringe benefits by denying the employer a tax deduction for the cost of such benefits or by assessing the employer with excise taxes on the value of fringe benefits in excess of a certain amount per employee.

(4) *Exclusions.*—Some items which might be regarded as employee fringe benefits should nevertheless be excluded from any list of taxable employee fringe benefits. At a minimun, we suggest the following: (a) Certain items should be considered as "working conditions" rather than as taxable benefits. Such a distinction should be broadly drawn so as to exclude from taxation those benefits which are provided for the health, safety or security of employees. For example, we think it would be bad

policy to tax employees with respect to such employer-provided items as alcohol rehabilitation programs or on-site exercise facilties. Likewise, no employee should be taxed because of the employer's decision to provide security devices or other protective measures. (b) We also believe that favorable consideration should be given to exempting benefits which, within a given industry or class of employers, are typically provided to employees as a matter of long-standing custom or tradition and which are closely connected to the employer's business. Employee discounts on goods manufactured by the employer would be but one example of such a benefit.

We thank the Committee for this opportunity to present our views on these important matters, and would be pleased to work further with the Committee and its staff to achieve a viable and equitable result.

Senator PACKWOOD. Mr. Blossom, let me ask you a couple of questions.

You talk about writing coverage for smaller companies, a local successful insurance person that has 20–25 employees, and it is insured as a group, I take it, of 20 or 25 people.

In that group, if one person has a catastrophic illness, that is used as an experience rating against that relatively small group?

Mr. BLOSSOM. I wouldn't want to overly generalize and say it has a direct dollar effect on that cost; but, yes, that particular incident would have an effect on the rating that would be done on that case in the second year, in most cases—in most cost-effective plans, anyway.

Senator PACKWOOD. Why is that? I'm curious. If you are talking about a genuine catastrophic cost that is clearly no fault of the employer nor not typically likely to recur, why is that taken into account in the experience rating of that employer?

Mr. BLOSSOM. The full catastrophic cost would not normally be considered; but a portion of it would be considered, because in essence the insurance company wants to recover the money that it has paid out through increased premiums.

Senator PACKWOOD. From that employer?

Mr. BLOSSOM. That is correct.

Senator PACKWOOD. All right.

Next, the large versus the small business generally—you cannot provide the same benefits levels for an employer of 100 people that you can for 1,000, I take it. So the company plan for 100 costs slightly more.

Mr. BLOSSOM. You can provide the same sorts of benefits. The problem is that it is much more difficult to provide some types of benefits on a more cost-effective basis.

For example, in Peoria, where I'm from, Caterpillar can provide health care management systems for their employees that they can afford to do with 27,000 employees; whereas, my company with 23 people in Peoria, I can't do that same thing.

Senator PACKWOOD. And so what you get to is, if it costs the large company $225 and it costs the small company $275, and they are both squeezed down to a $175 cap, the employees of the smaller company are going to lose out on some benefits simply because they work for a small company.

Mr. BLOSSOM. That is correct, particularly with preventive types of benefits.

Senator PACKWOOD. Whose employer might otherwise pay the $275 a month to cover them.

Mr. BLOSSOM. Gladly. Yes, sir.

Senator **Packwood**. Thank you. I have no more questions. I appreciate it.

We will take just about a 5-minute recess and then go on with the last panel of Mr. Philion, Mr. Bolger, and Ms. Keohane.

[Whereupon, at 3:08 p.m., the hearing was recessed.]

AFTER RECESS

The **Chairman**. Let's see now. I guess you are all here. Right?

Mr. **Philion**. Right.

The **Chairman**. Has anyone started?

Mr. **Bolger**. We are a new panel.

Ms. **Keohane**. We are all fresh.

The **Chairman**. You are fresh.

Well, I want to apologize for being a little bit late, but we have been scattered around today.

We can proceed in any way you wish. Your entire statements will be made a part of the record. If you can summarize the statements, we would appreciate it.

I don't have any order in which you may proceed, if you have it worked out.

Senator Kennedy is sorry he can't be here to introduce you, but we'll make his letter part of the record, and we appreciate your coming.

Ms. **Keohane**. Thank you.

STATEMENT OF NORMAN J. PHILION, EXECUTIVE VICE PRESIDENT, ACCOMPANIED BY WILLIAM M. HAWKINS, VICE PRESIDENT, TAX SECTION, AIR TRANSPORT ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. **Philion**. Mr. Chairman, we have a prepared statement and a summary statement for the record, and in the interest of your time we will summarize our summary.

We appear on behalf of the airlines of the United States, and I am accompanied by Mr. William Hawkins, our vice president of taxation.

Mr. Chairman, since the beginning of commercial air service 56 years ago the airlines have provided travel privileges to their employees for personal use. From the very outset these travel privileges have been considered by the Treasury Department to be gifts, exempt from income tax, because they are not a form of direct or indirect compensation or a substitute for wages. The benefit is usable only when empty and otherwise unused aircraft seats are available, and they are offered on a nondiscriminatory basis to all employees.

There have been several regulatory efforts, as you know, in recent years to change the tax treatment of fringe benefits, including airline employee travel privileges. Because of the tax policy questions involved the Congress has on several occasions enacted legislation prohibiting these regulatory initiatives.

Since the most recent legislative prohibition expires at the end of this year, we believe it is timely for Congress to consider the establishment of policy guidelines applicable to fringe benefits in order to clear up all of the uncertainty and confusion and to avoid the ongoing complexity and controversy of individual IRS rulings and interpretations.

Our prepared statement suggests policy guidelines for determining those fringe benefits properly excludable from gross income. They appear on pages 3 and 4 of our prepared statement, and they are based on a 1975 Treasury Department proposal that, because of questions about adequate legislative authority, was never finalized.

We respectfully urge your consideration of this suggestion.

Thank you very much.

The CHAIRMAN. Thank you very much.

[The prepared statement of Norman Philion follows:]

STATEMENT OF NORMAN J. PHILION, EXECUTIVE VICE PRESIDENT, AIR TRANSPORT ASSOCIATION OF AMERICA

My name is Norman J. Philion, Executive Vice President of the Air Transport Association, and I am accompanied by William M. Hawkins, the Association's Vice President of Finance and Taxation. We appear on behalf of the Association's airline members, who constitute the major segment of the airline industry, to present their views on the issue of taxation of fringe benefits as they may apply to free and reduced rate transportation provided by airlines to their employees and their families.

The airlines have provided travel privileges to their employees from the very beginning of commercial air service. Thus, the airlines have a deep interest in the current inquiry of the Committee into taxation of employee fringe benefits and welcome the opportunity to provide the Committee with our comments.

Airline employee travel privileges are and always have been considered to be gifts exempt from income tax by virtue of a Treasury Department Office Decision (OD 946) in 1921. The tax-exempt status of employee travel privileges has been subsequently reaffirmed by "Technical Advice" letters from the IRS National Office stating that airline employe travel privileges are exempt from tax because they are gifts and not part of the employee compensation package.

Federal courts have recognized repeatedly the gratuitous nature of airline employee travel privileges, usually in the context of liability litigation. Under common law principles of negligence, a carrier may limit significantly its liability to nonpaying passengers. In case after case, federal courts have ruled that the travel privileges were provided gratuitously, that those using the privileges were, in essence, non-paying, and that recovery for damages was possible only when the carrier's conduct constituted "gross or wanton negligence." [1]

Accordingly, it is clear that for decades, whether airline employee travel privileges were viewed from a taxation perspective or from a common carrier liability analysis, the same conclusion was reached—travel privileges were not compensation, they were gifts.

A number of years ago, several regulatory initiatives to change the tax treatment of fringe benefits, including airline employee travel privileges, were developed. The airlines opposed those initiatives, not only because they would have improperly reversed long-standing practice, but more importantly because they directly involve basic tax policy issues within the purview of Congress. As a result, the Congress, on a number of occasions, enacted legislation placing a moratorium on the regulatory initiatives, the most recent of which expires on December 31, 1983. In light of this, the airlines believe it is appropriate for Congress to establish practical and reasonable guidelines applicable to the taxation of fringe benefits, including airline employee travel privileges.

The first step in the development of a reasonable and equitable tax policy for fringe benefits is to determine those facilities, goods and services which are property excludable from gross income. Many tax authorities that have reviewed the matter agree that certain benefits ought to be excluded. However, disagreement arises as to the appropriate guidelines that should be applied in making this determination.

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[1] See *Sims* v. *Northwest Airlines, Inc.*, 269 F. Supp. 272 (S.D. Fla. 1967); *Braughton* v. *United Air Lines, Inc.*, 189 F. Supp. 137, 141 (D.Mo. 1960). See generally *Francis* v. *Southern Pac. Co.*, 333 U.S. 445, 449–50 (1947); *Kansas City Southern R. Co.* v. *Van Zant*, 260 U.S. 459 (1923); *Charleston + W.C.R. Co.* v. *Thompson*, 234 U.S. 576 (1914).

The airlines believe that legislative policy should provide that where an employer provides its employees with facilities, goods and services that exist incidental to its trade or business and are not a substitute for wages, the resulting benefits to employees, or their immediate families, should not be included in gross income if: (a) the facilities, goods or services are owned by or under the control of the employer for purposes proper to the business involved and are primarily unrelated to the personal use of such items by employees of the employer; (b) the facilities, goods or services are made available to the employees without the employer incurring substantial cost; and (c) the facilities, goods or services are made available on a non-discriminatory basis, subject to reasonable classification based on such factors as nature of work or seniority, but not based on income.

Additionally, the extension under like conditions of similar privileges by one company to employees of another company in the same trade or business should not be considered compensation subject to tax.

Also, the provision of facilities, goods or services should not be considered compensation includable in gross income when the amount of the item is so small or so difficult to value that the accounting for it would be unreasonable or administratively impractical.

This proposal is similar to guidelines proposed by the Department of Treasury in 1975, but which were not adopted because of a concern that clear legislative authority was lacking. In our opinion, it represents a reasonable and rational policy in an extremely difficult and sensitive area. It provides needed guidelines for both industry and government, and removes the cloud of uncertainty that exists.

APPLICATION OF PROPOSED POLICY TO AIRLINE EMPLOYEE TRAVEL PRIVILEGES

While the airline proposal may result in the taxation of some heretofore untaxed employee benefits, other benefits, including employee travel privileges, would continue to be excluded from gross income, as they have for more than four decades. An exclusion for airline employee travel privileges is warranted because: An airline's flight schedule and its frequency of operations are determined by economic considerations totally unrelated to the employee's travel. Airline employees generally travel on a space-available basis, using seats that would otherwise go empty, with their transportation resulting in little, if any, added expense to the airlines. Travel privileges are offered on a non-discriminatory basis to all employees. Under airline regulations, employees can neither give, sell or otherwise transfer the travel privilege to any other person, nor surrender them for cash or for any item of value.

Airline companies would incur substantial costs in developing and maintaining a tax withholding and reporting system if airline employee travel privileges were deemed to be compensation subject to tax. One of the major problems to be considered in such a system is the value of the airline travel privilege used by an employee. Valuing employee travel privileges would present an administrative and accounting nightmare due to the myriad of discount, stand-by and other conditional airline fares and in view of the rules and the significant restrictions placed upon airline employees using the travel privileges.

An additional point should be made on a matter which has been viewed with concern by certain employee fringe benefit analysts. The concern apparently is that employers will use or have used tax-free fringe benefits as a substitute for cash compensation or as a tactic for increasing compensation to employees in a tax-free manner. Whether this concern applies broadly to all classes of fringe benefits is unclear.

What is clear is that airline employees are highly compensated. Government studies over the years have shown again and again that airline employees are among the very highest, if not the highest, paid workers in the United States. In fact, in 1982 the average wage paid to airline employees was $31,800, while the average for U.S. industry was an estimated $18,300. As the repeated findings of federal agencies and courts have demonstrated, airline employee travel privileges are not a form of airline employee compensation.

CONCLUSION

The use by an employee of an employer's facilities, goods and services, when that use represents little or no cost to the employer and is available on a non-discriminatory basis, should result in no taxable income to the employee.

The basic test to be met in considering the tax treatment of employee fringe benefits is whether or not they really represent compensation. Airline employee travel privileges clearly do not. A rule of reason and practicality is required and this is the purpose of the guidelines suggested by the airlines.

STATEMENT OF WILLIAM A. BOLGER, EXECUTIVE DIRECTOR, NATIONAL RESOURCE CENTER FOR CONSUMERS OF LEGAL SERVICES, ALSO ON BEHALF OF THE AMERICAN PREPAID LEGAL SERVICES INSTITUTE, CHICAGO, ILL.

Mr. BOLGER. Thank you, Mr. Chairman.

My name is William A. Bolger. I am executive director of the National Resource Center for Consumers of Legal Services, and I'm also appearing here today on behalf of the American Prepaid Legal Services Institute.

I would like to note that with me today are Alex Schwartz, executive director of the institute, and Counsel Lee Irish of Caplin and Drysdale.

Both organizations are nonprofit membership organizations. They are concerned primarily with group legal service plans. Both have as members plan sponsors such as unions, cooperatives, and other associations, plan administrators, and service providers—that is, lawyers.

The resource center and the institute are coordinating the coalition to make section 120 permanent. Active participants in the coalition include the AFL-CIO, the American Bar Association, the Laborers International Union which pioneered group legal service plans, Midwest Mutual Insurance Company, the insurer with the most experience in legal service plans, and the United Auto Workers, whose new plan for General Motors employees and their families covers 1.4 million people.

I am here today to tell the committee about the broad support that legal service plans have earned from all parties, to stress the impact of Internal Revenue Code section 120 on the development of plans, and to remind the committee of the temporary nature of section 120 and the need to make it permanent.

Group legal service plans involve advance arrangements for meeting personal legal needs, especially for legal services that prevent or settle disputes. They have proven their ability to deliver high quality legal services at low cost. They are especially effective at preventive legal care at avoiding or resolving problems without expensive litigation.

Legal service plans deliver more legal services at lower cost. Both society and the individual member benefit. How and why? Because the transaction costs are reduced when advance arrangements are made on a group basis for providing needed legal services. These advance arrangements dramatically reduce the cost and uncertainty involved in selecting and consulting a lawyer when a legal question arises. Thus, people who are covered by a plan contact a lawyer more often, but at an earlier point in the course of a problem. More people receive legal advice about more matters, but matters are handled at lower cost and in a way that minimizes disputes and litigation.

Group legal service plans are supported by the labor and consumer movements, the legal profession, and the insurance industry. There is no opposition to them, really. The plans are in the best American tradition of pragmatic, voluntary group action to meet common needs.

Congress, too, has a pretty much unbroken record of supporting legal service plans, starting with an amendment to the Taft-Hartley Act in 1973, continuing with the enactment of section 120 in 1976, and most recently, in 1981, by extending section 120 for 3 more years.

Section 120, as you probably know, provides favorable tax treatment for employer-paid plans, including tough antidiscrimination rules similar to that of other statutory fringe benefits.

Section 120 has proven its effectiveness in stimulating the growth of legal service plans at a very minimal cost in foregone revenue. About 10 million people are presently covered by a plan, the largest portion of these in employer-paid plans; yet the 1982 revenue loss was just $20 million, according to a report of the Joint Committee on Taxation.

The reason this loss is so small is that plans are very inexpensive. Even the most comprehensive plan costs only $250 per family per year, and that's exceptional. The new UAW–GM plan costs just $40 per family per year. And costs have increased very little, if at all, over the last 10 years.

Now, despite this sterling record, the coalition to make section 120 permanent is very concerned that the section and the momentum it has helped create will be lost while Congress considers ways to control medical costs, reduce the Federal budget deficit, and insure that fringe benefits are fair to all employees; because if the Ninety-eighth Congress does not act, section 120 will expire, even though legal service plans have proven they meet a real and important social goal—that is, making legal services, especially preventive services, readily and inexpensively available to working Americans.

Legal service plans have shown that they deserve equal tax treatment with other statutory fringe benefits, so regardless of what other changes Congress makes in the tax treatment of fringe benefits, the important thing to us in the coalition is to make section 120 permanent so that a decade of progress toward equal justice will not be jeopardized.

Thank you.

STATEMENT OF NANNERL O. KEOHANE, PRESIDENT, WELLESLEY COLLEGE, WELLESLEY, MASS.

Ms. KEOHANE. Thank you, Senator.

My name is Nan Keohane. I am president of Wellesley College in Massachusetts, and I'm pleased to be here today as you consider the taxation of fringe benefits.

I will address the question of the tax treatment of traditional faculty housing programs, which are maintained by various educational institutions.

I am submitting for the record a written statement addressing the issue in greater detail.

I am speaking not only on behalf of Wellesley College but also on behalf of Amherst College, Smith College, Wesleyan University, and 14 educational associations which are listed in my written statement. These associations represent a wide range of both public and independent institutions of higher education, along with university professors and independent secondary schools.

Wellesley's faculty housing program involves the rental of houses and apartments to approximately 110 faculty members and certain administrators—for example, deans and their families.

Wellesley, like the other colleges I represent, maintains this program in order to have a substantial number of faculty members living as part of an extended campus community conducive to sustained interaction between faculty members and students. Living nearby makes it possible for faculty members to attend evening events on campus, to meet students informally, to invite students to their homes. It also increases opportunities for collegial working ties among faculty members. Such interactions between faculty and students outside the classroom or the laboratory are important to the distinctive education offered by a liberal arts college and other educational institutions.

I describe Wellesley's program as "traditional," because programs of this sort have existed for many years at numerous colleges, universities, and secondary schools across the country.

During the 19th century, Wellesley required all faculty members to live on campus. Although we are no longer able to have the entire faculty residing there, the faculty housing program continues to serve important educational objectives.

Under Wellesley's program, housing is rented to faculty members at a substantial rent that reflects the college's cost of providing the housing and maintaining it, and the value of the housing to our faculty members. No substitute cash living allowance is provided to employees who elect not to live in faculty housing.

For decades Wellesley has maintained this program, believing that the rents charged were reasonable to both the college and the faculty members.

The Internal Revenue Service, however, within the last few years has seen things differently. An IRS agent has asserted that because Wellesley could possibly have rented its housing units on the open commercial market at higher rents, the difference between the higher, theoretical fair rental value and the rent charged a faculty member constituted additional income to the faculty member. The agent also maintained that this income constituted wages paid by Wellesley, subject to income tax withholding and social security taxes, and argued that Wellesley should have withheld these taxes extending back to 1974.

The position of the agent was incorporated in formal action by the IRS at the end of 1981, when the IRS office issued releases affecting faculty housing programs at Amherst and Wesleyan.

It is our belief that the IRS position is incorrect for several reasons:

First, the value of the housing cannot be measured simply by what a business executive who commutes to Boston might be willing to pay. If Wellesley had to charge this rent, we would have to rent to these very business executives because our faculty would be squeezed out and the program would disappear.

The value of the housing must be measured with reference to Wellesley's costs, to the educational purposes served by the housing program, and the value of the housing to the faculty members.

Second, the IRS position violates the Supreme Court's 1978 holding in *Central Illinois Public Service Company* v. *the United States,* that an employer's obligation to withhold taxes must be precise and not speculative, and that an employer should not be treated as the guarantor of an employee's taxes.

We feel, in the light of numerous issues regarding the value of housing, that Wellesley did not have a clearly defined obligation in the past.

Third, the IRS position is contrary to Public Law 95-427, the fringe benefit moratorium which Congress has passed. There has never been a section or a regulation or a decided case that has provided that a traditional faculty housing program gives rise to wages subject to withholding.

We propose that Congress remedy this inequity in several ways:

First, to make clear through legislation that traditional faculty housing programs do not give rise to taxable income or wages, as long as costs are recovered;

Second, to clarify the application of the fringe benefit moratorium to traditional faculty housing programs through a bill such as that introduced by Senators Moynihan, Heinz, and Kennedy, bill 777.

I know these hearings are designed in part to uncover new sources of revenue to respond to our growing Federal deficit. Traditional faculty housing programs, however, do not provide a source of revenue. The alternative for educational institutions is to sell off the housing. The resulting cost to the Federal Government from homeowner deductions for mortgage interest and from property taxes would probably exceed the amount being sought by the IRS in these cases.

Thank you for giving me the opportunity to be here. I would be happy to answer any questions you may have.

[The prepared statement of Nannerl Keohane follows:]

STATEMENT OF NANNERL O. KEOHANE, PRESIDENT OF WELLESLEY COLLEGE

This statement, which addresses the tax treatment of traditional faculty housing programs, is being submitted to the Senate Finance Committee in connection with its review of the taxation of fringe benefits. It supplements the spoken remarks of Nannerl O. Keohane, the president of Wellesley College, Wellesley, Massachusetts, to the Committee on June 22, 1983.

This statement is submitted on behalf of Wellesley College, Amherst College, Smith College, Wesleyan University and the following 14 educational associations: American Association of State Colleges and Universities; American Association of University Professors; American Council on Education; Association of American Universities; Association of Catholic Colleges and Universities; Council of Independent Colleges; Federation of Independent Illinois Colleges and Universities; Independent Colleges and Universities of Missouri; National Association of College and University Business Officers; National Association of Equal Opportunity in Higher Education; National Association of Independent Colleges and Universities; National Association of Independent Schools; National Association of Schools and Colleges of the United Methodist Church; National Association of State Universities and Land-Grant Colleges. Although this statement specifically discusses Wellesley's faculty housing program, it is generally applicable to all educational institutions that maintain traditional faculty housing programs.

A. DESCRIPTION OF A TRADITIONAL FACULTY HOUSING PROGRAM

Wellesley operates a faculty housing program that rents houses and apartments to approximately 110 faculty members and certain administrators (for example, deans) and their families. The College maintains the program in order to have a substantial number of faculty members and administrators living on or near campus as part of an extended campus community, one that is conducive to informal interactions between faculty members and students. This sense of community has long been an integral part of the educational experience at Wellesley as a small, residential, liberal arts college. Yet whether an educational institution is located in a rural, suburban or urban setting a traditional faculty housing program, by creating a sense of collegiality among the faculty members and by encouraging student-faculty interaction outside the classroom, serves important educational goals of the institution.

During the 19th century Wellesley generally required all faculty members to live on campus. The President's report of 1900 stated that this practice "brought a body of intelligent and cultivated women into close contact with the student body, much to the advantage of the latter. The intercourse thus established has been helpful and beneficial in the highest degree. The spirit of unity and helpfulness has been largely fostered by this method of living * * * " Although times have changed considerably since 1900, and Wellesley is no longer able to have its entire faculty residing on campus, the faculty housing program continues to serve our educational objectives by having substantial numbers of faculty living on or near campus.

Wellesley's housing program is accurately described as a "traditional" faculty housing program because it resembles the housing programs that exist and have existed for many years at numerous colleges, universities, and secondary schools across the country. Under Wellesley's program, housing is rented to faculty members at a substantial rent that reflects the College's cost of providing the housing, the educational purposes of the College served by having faculty members living on or near campus, and the value of the housing to the College's faculty members. No substitute cash living allowance is provided to employees who elect not to live in faculty housing.

B. THE INTERNAL REVENUE SERVICE'S POSITION

Wellesley had maintained its housing program for decades, believing that the rents charged were reasonable to both the College and its faculty members.

The Internal Revenue Service, however, saw things differently. An IRS agent asserted that because Wellesley possibly could have rented its housing units on the open commercial market at higher rents, the difference between the higher theoretical "fair rental value" and the rent charged a faculty member constituted additional income to the faculty member. Furthermore, the agent maintained that this "income" to the faculty members constituted "wages" paid by Wellesley that were subject to retroactively-applied income tax withholding and social security taxes. The agent argued that Wellesley should have withheld these taxes during years extending back to 1974. The position of the agent was incorporated in formal action by the IRS at the end of 1981 when the IRS National Office issued two technical advice memoranda that treated traditional faculty housing programs at Amherst and Wesleyan as giving rise to retroactive withholding tax liability beginning in 1973 (Technical Advice Memoranda 8213005 and #8219001).

C. WHY THE IRS POSITION IS INEQUITABLE AND UNPRECEDENTED

It is our belief that the IRS position is both inquitable and unprecendented forseveral reasons, three of which will be touched upon in this statement. First, the value of faculty housing cannot be measured simply by reference to the commercial rental market. Second, the IRS position is contrary to the Supreme Court's holding in *Central Illinois Public Service Company* v. *United States*, 435 U.S. 21 (1978). Third, the IRS action appears to violate congressional intent in passing Public Law 95-427, the "fringe benefit moratorium". Each of these reasons will be discussed in turn, followed by a proposed legislative solution to this problem.

1. Valuation of faculty housing

The IRS maintains that the value of Wellesley's faculty housing must be measured purely by reference to the commercial rental market. Wellesley maintains, however, that the value of faculty housing must be measured with reference to: (i) the educational goals of the College served by the housing program, (ii) the value of the housing to the College's faculty members, and (iii) the College's cost of maintaining the housing.

It is not relevant to ask what a business executive would be willing to pay to live in Wellesley College housing because Wellesley is not a commercial landlord. Wellesley maintains it faculty housing program to further its educational goal of creating an extended campus coummunity and not as a means of raising money. As is discussed below, if Wellesley were to change its policy and rent its housing to the highest bidder the result would be the destruction of its faculty housing program, at great educational cost to the College.

Instead of referring to the commercial market, the value of faculty housing should be measured with reference to what is in fact the relevant market—the College's employees. The College has attempted to set its rent at a level that is high enough to recover most or all of its costs in providing the housing and yet low enough to enable faculty members to live in the housing. If the College raised its rents substantially beyond the normal adjustment for inflation, most or all of our faculty members would move to other towns where they would be able to rent housing at a lower price. This would create a pradoxical situation in which the Wellesley College campus, one of the important reasons that property values are so high in the Town of Wellesley, would become responsible for driving our faculty members out of town.

There are a number of cases in which courts have held that the value of property or services received by an individual, and included in his income, should be measured with reference to the value to the recipient and not to some theoretical fair market value. For example, in *Reginal Turner,* 13 T.C.M. 462 (1954), the court dealth with taxpayers who had won a free trip to South America and concluded that the trip was not worth its full retail value to them because they might well not have chosen to provide themselves with an item of such value. Faculty members who are given the opportunity to rent housing on or near campus should similarly not be subjected to taxation based on the value of the housing to some abstract third party. Rather, the value of the housing to the faculty member should be given primary attention.

A further reason why it is unreasonable for the IRS to refer only to the commercial rental market is that the IRS has itself taken a contrary administrative position on several occasions. The IRS in those instances has stated that the value of a particular fringe benefit is the employer's cost of providing the benefit rather than a theoretical fair market value. For example, in Technical Advice Memorandum #7740010, dated June 30, 1977, the IRS concluded that "the value of the [cafeteria] meals [furnished to employees] to be included in gross income is determined by the cost incurred in furnishing the meal less the amount charged for the meal" (emphasis added).

In light of the unique situation presented by faculty housing programs, case precedent, and the IRS administrative position discussed above, it seems clear that the "value" of faculty housing must be measured not with reference to an abstract commercial market, but to the educational purposes served by the housing program, the value of the housing to the faculty members, and the educational institution's cost of providing the housing.

2. *Central Illinois*

An employer is not required to withhold taxes from all of the income that is received by an employee, but only from the "wages" that he pays to the employee. The term "wages" is defined in section 3401 of the Internal Revenue Code, with regard to income tax withholding, as "remuneration for services." A similar definition is found at section 3121 with regard to social security, or "FICA" (Federal Insurance Contributions Act), taxes.

In 1978 the Supreme Court held in the *Central Illinois* case, cited above, that a taxpayer/employer was not liable for withholding tax on the payment of lunch reimbursements to employees even though such payments clearly constituted taxable income to the individual recipients (because they were not excludable under Section 119[1] of the Internal Revenue Code). The Supreme Court concluded that the taxpayer had no duty to withhold because its liability was not "clearly defined" and because an employer should not be a guarantor for the payments of its employee's tax. In its decision, the Supreme Court rejected the argument made by the IRS that an item which is income to the employee because it is outside the exclusion of Section 119 is also automatically "wages" (i.e., "remuneration for services") for withholding purposes.

As is discussed further below, no Internal Revenue Code section, regulation, ruling, or decided case has ever stated or held that participation in a traditional faculty housing program constitutes "wages" subject to withholding. In light of this absence of precedent and the fact that traditional faculty housing programs have operated for decades without objection by the IRS, educational institutions can hardly be said to have a "clearly defined" withholding obligation. Moreover, substantial case law (cited by the Supreme Court in *Central Illinois)* has held that an employer is not required to withhold where an item is provided for a dominant business purpose other than compensating employees. In this case, Wellesley's purpose in maintaining the faculty housing program is educational—to create an extended campus community with regular interchange between faculty and students. *Central Illinois* therefore precludes the assessment of retroactive withholding taxes against educational institutions maintaining traditional faculty housing programs.

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[1] Section 119 provides an exclusion from income for meals or lodging furnished to an employee (i) for the convenience of the employer, (ii) on the business premises of the employer, and (iii) (in the case of lodging) where the employee is required to accept the lodging as a condition of employment.

In Revenue Procedure 80-53, 1980-2 C.B. 848, the Internal Revenue Service published its response to the *Central Illinois* decision. The Revenue Procedure generally provides that withholding will not be required where (a) the employer had a "reasonable basis" for its belief that the benefits should not be considered remuneration for services and (b) no statute or other legal authority specifically required withholding.

The "reasonable basis" aspect of the Revenue Procedure 80-53 test is clearly satisfied by Wellesley because of the reasons discussed in section C.1 above, the lack of any decided cases requiring withholding on account of traditional faculty housing programs, the fact that our program and similar programs across the country have existed for decades without objection by the IRS, and the substantial case law supporting non-withholding in view of Wellesley's business, i.e. educational, purpose in maintaning the housing program.

The IRS, however, has asserted that faculty housing programs such as Wellesley's fail the other part of the Revenue Procedure 80-53 test—that no statute or other legal authority required withholding. This position of the IRS was announced in the technical advice memoranda concerning Amherst and Wesleyan and is based on an unusual and unsupported extension of an argument first officially stated by the IRS in 1981 in Revenue Ruling 81-222, 1981-2 C.B. 205. Revenue Ruling 81-222 indicates that meals and/or lodging which are not excluded from taxable income by Section 119 of the Internal Revenue Code automatically constitute "wages" subject to withholding, without regard to the usual and fundamental question in determining "wages"—whether such items were provided as "remuneration for services."

The IRS contended in the technical advice memoranda that the institutions did not satisfy the requirements of Revenue Procedure 80-53 on the theory that a specific requlation—Reg. Section 31-3401(a)-1(b)(9)—treated the housing in question as "wages." That regulation, however, simply states the obviously sound rule that amounts excluded from income under Section 119 will not be treated as "wages" subject to withholding; it in no way suggests that other meal and lodging items (assumed not to be covered by Section 119) are necessarily "wages" without regard to the question of whether they constitute "remuneration for services" in the first place. In the technical advice memoranda, the IRS said that Revenue Ruling 81-222 "restated" this "principle."

The IRS position, and the application of Revenue Ruling 81-222 to traditional faculty housing programs, is inconsistent with the Supreme Court's *Central Illinois* decision. The *Central Illinois* case itself involved a meal and lodging item—a meal allowance—found not to qualify for the Section 119 exclusion. If the IRS rationale in Revenue Ruling 81-222 were applied to *Central Illinois* one would conclude that because the lunch reimbursements did not satisfy section 119 they necessarily constituted wages subject to income tax withholding. And yet the Supreme Court's holding was exactly the opposite: despite the fact that the lunch reimbursements were not excluded from "income" by Section 119, they did not fall within the "much narrower" category of "wages." In any event, even if the position stated in Revenue Ruling 81-222 were correct (and we think it is entirely incorrect as applied to traditional faculty housing programs), it would hardly affect an institution's "reasonable basis" for not withholding during years prior to 1981.

It should be noted that Revenue Ruling 81-222 need not be regarded as incorrect if it is properly limited to the factual situation it describes—namely, the provision of free meals or housing. The provision of free meals or housing would arguably involve remuneration for services because it would relieve the employees from a personal expenditure they would otherwise have to incur. This is not the case with respect to traditional faculty housing programs charging rents reflecting the value of housing to the employees.

3. The fringe benefit moratorium

In 1978, in response to Treasury's attempts to expand broadly the taxation of fringe benefits, Congress enacted the "fringe benefit moratorium" (Public Law 95-

427), prohibiting the issuance of new regulations in the fringe benefit area. Moreover, Congress made it clear in legislative history that the moratorium "would prevent the IRS from deviating from the present administration of the tax laws as they concern the taxation of fringe benefits as compensation." House Report No. 95-1232. The Report states that the moratorium was imposed because Congress recognized that the lack of uniformity in the fringe benefit area led to inequitable distinctions between taxpayers receiving similar benefits, difficult decisions as to an employer's obligation to withhold taxes, and difficult valuation problems regarding fringe benefits. the fringe benefit mortorium has been extended twice by Congress, most recently by P.L. 97-34, § 801, and remains in effect through December 31, 1983.

The fringe benefit moratorium applies to traditional faculty housing programs because such programs have not previously been challenged by the IRS, because there is no direct legal precedent for imposing additional employment taxes on institutions maintaining such programs, and because the IRS attack on faculty housing programs represents a departure from the cost measure of value which the IRS itself has utilized in other cases.

The IRS has argued on several occasions, such as in the technical advice memoranda concerning Amherst and Wesleyan, that there are cases that establish a precedent for taxing traditional faculty housing programs. For example *Benninghoff* v. *Commissioner,* 614 F.2d 398 (5th Cir. 1980) aff'g 71 T.C. 216 (1978) (free housing provided to Panama Canal Zone policeman); *McDonald* v. *Commissioner,* 66 T.C. 223 (1976) (lodging rented to business executive in Tokyo). Those cases do not bear directly on traditional faculty housing programs for several reasons.

These cases, which interpret section 119 of the Internal Revenue Code, do not affect the applicability of the fringe benefit moratorium. It is not sufficient for the IRS to argue that because it has taxed isolated business executives who have received free or discount housing in compensatory circumstances there is a precedent for taxing faculty housing. Traditional faculty housing programs have a completely different purpose from typical corporate perquisites, especially in light of the substantial rents charged and the educational objectives served by the programs.

The IRS also cites *Goldsboro Christian Schools, Inc.* v. *United States,* 78-1 USTC 9191 (E.D.N.C. 1977) and *Bob Jones University* v. *United States* 670 F.2d 167 (Ct. Cl. 1982) for the proposition that there is a precedent for taxing faculty housing. *Goldsboro* and *Bob Jones* involved the provision of free housing to employees at institutions that the Supreme Court recently found not to be tax exempt because of their policies of racial discrimination. Neither *Goldsboro* nor *Bob Jones* support the IRS's position with regard to traditional faculty housing programs. Those cases are clearly distinguishable from traditional housing programs where reasonable rents are charged that reflect the educational institution's costs and the value of the housing to the employees. In *Goldsboro* and *Bob Jones* the housing was provided free of charge to the employees, the housing was obvisouly provided at substantial expense to the employer, and in some instances employees who did not live in the free housing were offered a cash stipend. The employes in those cases also received other substantial benefits such as free utilities, free food, free medical care and free insurance. In these circumstances, the provision of free housing and other benefits necessarily relieved the employees of personal expenses and thus involved taxable compensation. Therefore, the result in *Bob Jones* and *Goldsboro* although not surprising, has no direct bearing on the applicability of the fringe benefit moratorium to a tax-exempt educational institution which charges reasonable rents reflective of costs, and which does not offer a cash alternative.

Congress recognized when it passed the fringe benefit moratorium that Section 61 of the Internal Revenue Code and the Regulations thereunder provided on their face for the taxation of every item provided in kind by an employer at less than its value. However, Congress also recognized that despite this principle the IRS in fact has not challenged certain fringe benefit practices, and the moratorium was intended to maintain that status quo until Congress itself could review the entire fringe benefit area. See House Report No. 95-1232. Thus, for example, while the IRS would tax a top salesman who was awarded an airline trip to Hawaii by his employer, the IRS had not taxed widespread programs for providing free or virtually free airline travel to flight attendants. The latter benefit, which involves special circumstances such as the fact that the employer did not incur any substantial marginal costs, is thus protected by the fringe benefit moratorium while the former benefit is not. Just as the flight attendant who receives free travel is distinguishable from the salesman who receives free travel as bonus compensation, traditional faculty housing programs are distinguishable from housing provided in the business context or provided free of charge at Bob Jones University or at Goldsboro Christian Schools, Inc. Indeed, traditional faculty housing programs are not unlike the provision of free travel to flight attendants in that in both cases the benefit is provided at little or no unreimbursed cost to the employer.

Finally, as noted above, the IRS itself has applied a cost measure for so-called fringe benefits, specifically with respect to cafeteria meals. To seek to apply a commercial market value measure to traditional faculty housing programs is therefore a change in IRS practice which Congress sought to prevent when it enacted the fringe benefit moratorium.

D. PROPOSED LEGISLATIVE SOLUTION

We propose that Congress remedy the inequity created by the IRS' attempts to override *Central Illinois* and the fringe benefit moratorium and to collect retroactive withholding taxes from educational institutions maintaining traditional faculty housing programs.

First, for the future, Congress should make it clear through legislation that traditional faculty housing programs do not give rise to taxable income or wages subject to withholding as long as the institution's costs are recovered. Such legislation might provide, for example, that faculty housing programs give rise to income only to the extent that an educational institution's rents do not recover the costs of providing the housing. Although such a standard would involve a calculation of "costs", and would therefore not be purely mechanical, the system of taxation proposed by the IRS involves the much more speculative estimation of the "fair rental value" of the housing. A bill introduced by Senator Moynihan last year, S. 2872, provided for such a solution to this issue.

Second, as to the past and present, Congress should clarify the application of the fringe benefit moratorium to traditional faculty housing programs, so as to prevent the imposition of retroactive withholding taxes. Senate Bill 777, introduced by Senators Moynihan, Heinz, and Kennedy, would accomplish this objective. (S. 777 is identical to section 202 of H.R. 7094, approved unanimously by the Senate Finance Committee last September).

Finally, if the fringe benefit moratorium is extended beyond December 31, 1983 in order to provide additional time for Congress to reach a comprehensive resolution of the fringe benefit area, Congress should make it clear that the moratorium applies to traditional faculty housing programs, both as to the past and for any extension period.

E. REVENUE IMPACT

I know that these hearings and those scheduled to follow are designed in large part to uncover new sources of tax revenues which may be available to respond to our growing federal deficit. Traditional faculty housing programs, however, do not provide a source for revenue. The alternative for educational institutions is to sell off the housing; the resulting cost to the Federal Government from homeowner deductions for mortgage interest and property taxes would in all likelihood exceed the amount being sought by the IRS in these cases.

F. CONCLUSION

I urge you, on behalf of Amherst College, Smith College, Wellesley College, Wesleyan University and the many institutions and individuals represented by the educational institutions listed above, not to allow this inequitable situation created by the Internal Revenue Service to continue. Wellesley, in its effort to provide excellence in all aspects of education, has maintained its faculty housing program for almost 100 years. The continuing need for excellence in American education, an excellence that must exist both within and without the classroom, calls for your support of such programs rather than for their destruction at the hands of the Internal Revenue Service.

The CHAIRMAN. Thank you very much.

It's sort of a broad-based hearing. We are trying to cover a number of areas, and certainly, in my view, we shouldn't do it piecemeal. We ought to package all of this together and keep it together rather than to say, "OK, we'll take care of prepaid legal services," and then we'll take care of something else, then we'll save the hard part till last. In my view you put it all together, and everybody makes a contribution that way. But whether or not I have the votes to do that will depend—whether or not anything is done, I guess, depends on how many votes you have.

But I do have just a few questions. Again I apologize for the delay.

Ms. Keohane, should the rules you would apply to faculty housing be applied to housing provided by other employers? Is there a distinction between faculties and somebody who works for a corporation somewhere? Is there some reason for a distinction?

Ms. Keohane. We think there is a distinction, because the kind of sustained communication that I described, which means dialogs late into the night, and holding seminars in the house, is part of what we believe makes our education, our very program and product distinctive. And I don't believe that the same kind of intensity can be argued for a corporate housing program, even if collegiality in a more diffuse sense is served.

The Chairman. Which employer-fixed costs would you include in your definition of "the employer's cost providing the benefit"? Does that include insurance?

Ms. Keohane. It includes insurance, it includes maintenance on a regular pattern, it includes any kind of momentary maintenance which is required by things breaking down—all the costs beyond the bare fact of having acquired the houses originally, that are needed to keep them up.

The Chairman. Well, I think there is considerable sympathy for addressing this particular area. We know of the Treasury's opposition. Perhaps there is some way we can satisfy most of your concerns and most of their concerns, but not all of either's concerns. That's a possibility.

Ms. Keohane. Well, we are very happy to have as many as possible of our concerns addressed.

The Chairman. Well, that's generally not a bad attitude.

I want to get back to the airlines. I remember the last time—when did we extend the moratorium last?

Mr. Philion. Two years ago, I believe.

The Chairman. Yes. I was on a flight to Kansas City, as I recall. I don't know who was flying the plane; they were all back around me, lobbying. I think it was on automatic pilot.

And at that point I would have said yes to anything. I'm sure there was somebody up there, but I wasn't. [Laughter.]

And I guess the point is that it is an area we ought to address. We ought to clarify some of these issues and lay it to rest. Hopefully we can do that.

How are free airline passes provided to employees, unrelated to employee personal use? One of your tests is that it has to be related to personal use.

Mr. Philion. Yes. I think that's one of the meaningful guidelines that ought to be considered. Airlines provide free or reduced-rate transportation for reasons other than personal use. A great number of airline employees have to be moved about for business purposes. Clearly, that's a method of doing business. A crew may have to be moved from New York to Chicago; that's not personal-use. I would say about half of the transportation provided to airline employees is in that category. But there is personal use transportation used by airline employees, and has been since the beginning of air transportation.

I think a tax would be a bad blow. You would be sitting with crews and others on your next flight if the IRS gave consideration to some new ruling affecting the tax treatment of airline passes.

The CHAIRMAN. But is it a policy of all airlines to allow any employee as many travel privileges as the employee requests?

Mr. PHILION. No. There are a number of factors involved, and airlines differ among themselves in the treatment of airline passes.

They are definitely not discriminatory. I think the usual rule is you have to be employed for 6 months or a year before you are entitled. And as your seniority grows, you are entitled to a greater number of passes. But they are nondiscriminatory, and they do not represent any form of compensation.

The CHAIRMAN. Well, do some airlines charge after a certain number of flights?

Mr. PHILION. Most airlines impose a service charge of one kind or another that may differ based on the length of the trip, the season of the year, and we pay transportation taxes on those service charges.

I would say most of the personal use passes in being today have a service charge imposed to cover out-of-pocket expenses.

The CHAIRMAN. I guess the key question is, under your test what facts and circumstances would you use to determine whether a fringe benefit is a substitute for wages? How would you make the determination? When is it a substitute for wages?

Mr. PHILION. Well, it never has been, Mr. Chairman, and I think that's clear both to the airline employers and to the airline employees. It is not covered, or——

The CHAIRMAN. Is that because you say it isn't?

Mr. PHILION. It is not dealt with in any labor contract of any kind, and most of the benefits that airline employees enjoy, in one shape or another, are based on labor contracts. Most of the airline wages and compensation programs are negotiated and appear in contracts.

The CHAIRMAN. But I guess my point is, there may be other people in similar circumstances where the same consideration might be construed to be wages, and I think the problem is fairness. Is it fair to people generally? Or are we flirting with becoming a fringe-benefit society, and if so, who is going to pay the taxes?

Mr. PHILION. I think if you look at the record of airline wages and total compensation and compare it with business as a whole in this country, you will find that airline employees are among the highest-paid workers in the country. And we don't need to use a benefit such as a personal-use travel pass as a method of compensation, and we have never done so.

The CHAIRMAN. No, I think there is a need for many of the things that are being done, don't misunderstand me. But as you indicated in your "summary of your summary," we need to clarify it and lay it out and say, "OK, this is it." Now, whether we can do that legislatively or whether we have to continue to rely on IRS and regulations—but I'm hopeful we can address it, just as I am hopeful we can address prepaid legal services.

Here again, I assume 10 or 20 years ago we were looking at health care costs—I don't know what it was 20 years ago, but I think the cost of a revenue impact of prepaid legal services is about what? Fifty million a year in revenue?

Mr. **Bolger**. I believe it was 20. But it was under 50.

The **Chairman**. But what is it going to be 20 years from now if we don't put some safeguard? Let's say we made it permanent but had some limit. That's the thing that is going to eat us up around here. No one ever puts a limit on it, saying, "Oh, it's a great program; it's never going to get out of hand." That's what they said about medicare. They told us it would be $11 billion by 1990, and now they are saying, "Oh, we just made a little mistake; it's going to be $110 billion." It's $57 billion this year.

So that may be some area there we might address, then you wouldn't have to come back every 3 years.

Mr. **Bolger**. We would like that very much. I think we could probably live with any kind of reasonable limit, because we are very confident that there is not going to be much cost escalation in these legal services. It's hard to see how that could really happen.

I think the analogy with the medical care experience is an obvious one to make at first blush, but then when you start to look at it more closely you see they are just not the same.

The **Chairman**. No, I am not trying to make the analogy. Obviously there is a vast difference. But I am just saying it's like any other program that starts out open-ended.

Mr. **Bolger**. I can certainly see the concern.

The **Chairman**. It's called "entitlement." Some of the programs are entitlement programs.

Well, again, we appreciate your testimony very much. I think, as you are aware, we did pass out last year a bill to address your concerns of faculty housing. It was opposed by the Treasury. I haven't read their full statement today; I assume it is probably still opposed by the Treasury. But again, there may be ways to bring together the important points and resolve any differences for the most part.

We will have additional hearings on this entire area. Let's see, when does the moratorium expire?

Mr. **Philion**. The end of the year.

The **Chairman**. And yours is the end of the year.

Mr. **Bolger**. Actually, it is the end of next year.

The **Chairman**. Oh, next year. Oh, you are here early. [Laughter.]

Mr. **Bolger**. Yes.

The **Chairman**. We may see you again next year. [Laughter.]

Mr. **Bolger**. We would like to avoid that.

The **Chairman**. If you just leave this year's statement, I'll put it in for you next year. [Laughter.]

And we are looking at faculty housing. It is a matter that I am certain Senators Kennedy, Moynihan, Heinz, and probably every other person who has a university or college, whatever. And I assume there is some justification for it, at least you made a good case.

Is there actually a lot of this dialog that goes on if they live on the campus as opposed to living off campus? Do a lot of students combine and drop in and say, "I'm here because you have this housing"? [Laughter.]

Ms. **Keohane**. A mixed blessing, I suppose, at best. No, there is. I can testify from my own experience, both as a faculty member and as a student at three or four of such institutions.

The **Chairman**. Is there a sign on the house that says, "This is covered by faculty housing subsidies"? [Laughter.]

Ms. **Keohane**. We do try to assume that privacy of faculty members is respected, too. But it is the possibility of being able to hold a seminar there, which is a very different feeling from always having it in a seminar room. And it's not just the house itself, in fact, but the proximity that does make it possible for people to come and join students in planning a theater production. If you live in Cambridge it is much harder to do that, or Boston. It makes an enormous difference in the tenor of life on campus. And that I can tell you happens with every single faculty member. They do participate more, and it makes a difference.

The **Chairman**. I assume that can happen. I haven't been in school for a while, but I appreciate that.

If there are any others who might be in the hearing room who want to submit statements for the record, the record will be open. If not, we will stand in recess, subject to the call of the Chair. And thank you very much.

Ms. **Keohane**. Thank you.

Mr. **Philion**. Thank you.

Mr. **Bolger**. Thank you.

[Whereupon, at 3:52 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

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June 23, 1983

The Honorable Robert Dole
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Bob:

Enclosed please find testimony prepared by the President of Wesleyan University, Colin G. Campbell, regarding the taxation of faculty housing.

As Wesleyan University is one of the more prestigious universities in the state of Connecticut and in light of the Committee's interest in the taxation of fringe benefits, I request that the full text of President Campbell's testimony be included in the final hearing record, and that serious consideration be given to the points raised in this testimony.

I thank you in advance for attention in this regard.

With kindest regards,

Sincerely,

Lowell Weicker, Jr.
United States Senator

LW/sh
Enclosure

Statement on Faculty Rental Housing before the Senate Finance Committee

by

Colin G. Campbell, President
Wesleyan University
Middletown, Connecticut

June 22, 1983

Mr. Chairman, Wesleyan is a small university that takes great pride in offering an excellent liberal arts program with instruction by an outstanding faculty in a stimulating, congenial environment. Like Amherst, Smith and Wellesley Colleges, Wesleyan makes every effort to encourage collegiality among its faculty and informal contact between students and faculty outside of the classroom and laboratory. We do this so that our communities will be interesting places to live and work and our students will have the greatest variety of opportunities for intellectual and personal growth.

An important aspect of our efforts to foster a lively community where faculty actively participate in a wide range of campus activites is the opportunity for faculty to live near the campus. In Middletown, Connecticut where Wesleyan is located, such housing for faculty would not be available unless the University owned and rented properties to faculty.

I want to emphasize that the institutions do not provide free housing; typically rentals cover the cost of maintenance, local property taxes and other institutional expenses. Furthermore, by acquiring houses as they come on the market, an institution allows for eventual expansion if and when the need exists without disrupting the neighborhood. In the University's case, one of the original reasons for acquisition of the faculty housing was to provide it with a "buffer zone" for future expansion needs.

The Internal Revenue Service, we believe, is wrong to maintain that when a college rents houses to faculty for less than it might receive from renters outside the institution, the difference in rate constitutes "income" for the renter, and the college should withhold taxes on it. We contend that by providing rental housing for faculty the University is filling an important and legitimate educational need.

As you know, we were unsuccessful in our efforts to seek legislative relief for our institutions in the last session of Congress. We therefore urge you to recommend to the Senate that the rent charged for faculty housing be exempt from taxation. Failing this we urge that the Committee at a minimum review and consider the issue of faculty rental housing in conjunction with the other so-called fringe benefit items.

STATEMENT OF
HENRY A. DUFFY, PRESIDENT
AIR LINE PILOTS ASSOCIATION, INTERNATIONAL
SUBMITTED TO THE
COMMITTEE ON FINANCE
U. S. SENATE
JUNE 22, 1983
TAXATION OF EMPLOYEE FRINGE BENEFITS

Mr. Chairman and members of the Committee, I am Captain Henry A. Duffy, President of the Air Line Pilots Association, International (ALPA), which represents the professional interests of more than 34,000 pilots employed by 46 air carriers in the United States. The members of ALPA welcome the Committee's examination of the tax treatment of employer-provided medical care and other employee fringe benefits, and we appreciate this opportunity to present our views.

The Committee's review of the range of employee fringe benefits and their tax treatment is timely, given the expiration at the end of this year of the Congressional moratorium on Internal Revenue Service promulgation of regulations in this area. We urge the Committee, after its review, to develop legislation that would establish a consistent policy providing clear statutory guidance governing the taxation of fringe benefits. Absent the time or conditions necessary to legislate on this issue by the end of the year, we support an extension of the moratorium so that a reasoned and comprehensive approach to this matter can be taken.

With regard to the specific issues before this Committee, in February of this year the Administration proposed, as a component of its 1984 fiscal year budget submission, a limit of $175/$70 a month (family coverage/single coverage) on the amount of employer contributions to a health plan that can be excluded from federal tax. As envisioned by this plan, effective January 1, 1984, employees would pay payroll and income taxes on contributions above the limit. This was estimated to increase federal revenues by $12.7 billion over the fiscal 1984-86 period. In addition to the revenue-generating feature of this proposal, the fundamental assumption behind this proposal is that consumers of health care will become more cost conscious in their purchase of health insurance and health services as they are required to bear a greater proportion of health cost.

The Air Line Pilots Association strongly opposes the imposition of any ceiling on tax-free employer contributions to employee health benefit plans. We believe there are a number of compelling reasons to oppose such a measure:

- The cost-containment rationale behind this proposal ignores the basic fact that the medical care market place is controlled by those who provide the services, not those who purchase them. Better than 70% of all health care decisions are made by physicians, not consumers, and medical costs derive from those decisions.

- The proposal makes no allowance for the high variability in health care costs in different sections of the country. An employee receiving coverage and living in the Northeast - where health care costs are high - would have the same tax ceiling as his counterpart living in the Southeast, where medical costs are generally much lower.

- It is highly discriminatory in that it makes no allowance for an employee's age or number of dependents - additional factors - which are critical in determining the cost of health care.

- The tax cap would not take into account cost inflation in future years. Employees would find over time that their current level of insurance coverage would be rapidly eroded.

We represent employees covered by 46 separate medical benefit plans. The specific ceilings which have been suggested would immediately affect many of the plans covering our members. And, the ceilings would certainly affect them all in the near term, as monthly medical-dental family premium rates currently range up to two hundred dollars, and are continuously rising. Other adverse consequences include the disruption of our existing collective bargaining agreements and the effect such ceilings would have in imposing a restrictive influence on future labor-management negotiations.

We view this as an ill-conceived proposal that would raise taxes on individuals and penalize working men and women throughout the country for achieving, through the collective bargaining process, sound health insurance coverage for themselves and their families. We strongly urge the Committee's opposition to such a measure.

Beyond this specific Administration proposal, we believe that Congress should provide certainty to employees and employers by establishing a set of principles or guidelines that would seek to define, as a matter of law, the types of fringe benefits which would not constitute compensation includable in gross income subject to tax. We support retention of provisions in existing law which allow tax exempt treatment for benefits such as qualified pension plans, group life insurance and health benefits among others. Beyond that, in general, we believe an employer should be able to share with his employees, on a non-taxable basis, facilities, goods and services that:

- are incidental to the trade or business;
- are available in such a manner that the employer does not incur substantial additional cost; and
- are made available to employees on a non-discriminatory basis.

With regard to fringe benefits unique to the airline industry, we are concerned about federal policy relating to a benefit that dates from the very beginnings of commercial air service --- the granting by airlines of free or reduced-rate travel passes to their employees. Historically, this low-cost travel for airline employees has been considered a benefit as opposed to a form of employee compensation and therefore has not been subject to income tax. This policy dates from the 1920's when the IRS ruled that:

> "Personal transportation passes issued by a railroad company to its employees and their families to be used when not engaged on business for the company, and which are not provided for in the contract of employment, are considered gifts and the value thereof does not constitute taxable income to the employees."

The IRS reaffirmed this ruling as recently as 1975 in Memoranda to District Directors. In the same year, it issued a "discussion draft" on taxation of fringe benefits that included a "general rule." This rule held that employees do not receive taxable compensation when the benefit, such as a seat on a scheduled airline flight, is on hand anyway, costs nothing additional to provide and is widely offered on a non-discriminatory basis. The draft cited airline employee travel privileges as an example of a benefit that is non-taxable.

Thus, the policy on tax treatment of passes to employees of transportation companies has been well-established for almost sixty years. ALPA strongly believes, Mr. Chairman, that this historical precedent should be an important guide to the Congress in its consideration of this issue.

In addition, there are other objections to treating airline travel passes as income.

First, there are a number of restrictions on employee use of the travel pass. The employee cannot make a reservation and is not guaranteed a seat; passes provide only space-available transportation. The airlines have strict rules that an employee traveling on a pass cannot displace a fare-paying passenger. Thus, if the airplane is full, the employee is left at the gate. In that case, he or she faces either the additional expense of meals and lodging until a seat is vacant or paying the regular fare. In addition, airlines frequently eliminate or restrict pass travel for commercial reasons at busy travel times such as holidays. For example, in the past, several airlines faced with heavy traffic and a large number of reservations, have temporarily stopped employee travel on the North Atlantic at various times.

Second, it would be difficult to determine the dollar value of "income" from the pass. For example, an airline employee uses his travel pass to fly on a space-available basis from Washington to Los Angeles. Should the "income" for tax purposes be the price of the regular coach fare, a discount fare that is 20, 30, 40 or 50 per cent less than the regular fare, or the negligible cost to the airline of actually carrying him?

In sum, Mr. Chairman, we hope the Congress would be able to address the issue of fringe benefit taxation in a comprehensive manner consistent with the approach we have outlined. The Air Line Pilots Association appreciates the opportunity to present its views, and we look forward to working with the Committee to achieve a sound and equitable resolution of this policy question.

AMERICAN ACADEMY OF ACTUARIES

ONE-PAGE SUMMARY OF TESTIMONY

JUNE 22, 1983

1. As a professional association, the American Academy of Actuaries neither supports nor opposes legislation to tax employer-paid health insurance above a specific amount.

2. A tax-cap linked to premiums is flawed:
   a. Premiums are not well defined and may not even exist (i.e., self-insurance).
   b. A premium approach is inequitable since the premium level is often more a function of the size and composition of the group than of the coverage level.

3. An alternative design would use coverage provided instead:
   a. This approach is more equitable.
   b. There is a clear precedent in the taxation of group life insurance.
   c. The coverage level could be assigned a "richness index" in which special recognition is possible for health maintenance organizations, other alternate delivery systems, or outpatient-intensive coverages.

AMERICAN ACADEMY OF ACTUARIES

SENATE COMMITTEE ON FINANCE
HEARINGS ON FRINGE BENEFITS RE HEALTH "TAX CAP"
STATEMENT OF COMMITTEE ON HEALTH INSURANCE
AMERICAN ACADEMY OF ACTUARIES
ROBERT H. DOBSON, CHAIRMAN
JUNE 22, 1983

The American Academy of Actuaries is a professional association representing actuaries in all aspects of actuarial practice. Members of the Committee on Health Insurance who prepared this testimony are employed both as consultants and by insurance companies. For purposes of this testimony, however, we speak as professional actuaries and not on behalf of our clients or employers.

As a professional association, the Academy neither supports nor opposes legislation to tax employer-paid health insurance above a specific amount. We do, however, have a major concern with the technical form of the proposal being considered. That is, we believe that if there is to be a tax-free limit it should not be based on premiums, but rather on coverage provided.

Health coverage is not a commodity. It does not have a price as such. Many cases are self-insured and have no known price until months or even years after the experience period. Even in cases that are fully underwritten by an insurance company, the price charged per member of the group is often more a function of the make-up of the group than of the coverage level. We do not believe it is equitable to base the amount of tax which a person has to pay on the content of the group of which he is a member.

Consider the following example.

Three employers based in the same city provide identical fully paid health coverage to their employees. Employers A and B have five employees each while Employer C has thirty employees.

Employer A purchases coverage from an insurer, but has to pay $80 for individual and $200 for family coverage, because of the small size of the group. Employer B, faced with similar rates, decides to self-insure. He pays nothing until or unless there is a claim. Employer C pays $60 and $150 for coverage, based on his greater number of employees.

If claim payments for Employer B average less than $75 and $175, the only employees which will be taxed are those of Employer A, though they receive coverage identical to the others. They are taxed because they work for a small employer.

The same undesirable result, higher taxable premiums for the same coverage, can be caused by the demographic make-up of the group or the industry in which the employer is engaged. For example, for the same coverage, a group of employees whose average age is 35 may incur no tax while a group whose average age is 50 would be taxed. Similarly, an employee group in higher risk employment may be taxed while a white-collar group would not be even though the size, age composition, and geographical location of the two groups are identical.

The means of funding the employer-paid health coverage is a second major problem area. In our example, Employer B is self-insured. Consider what happens if one of his employees need open-heart surgery for $25,000. Spreading the cost of the program over the five employees, they each have additional taxable income of $5,000.

These problems have been recognized and solved by Congress before.

There is a very clear precedent in the current taxation of employer-provided life insurance coverage above $50,000. That is, the IRS provides a table, and the individual is taxed according to the value of insurance coverage received, which bears no relationship whatsoever to the actual price paid for the coverage. Although determination of such a standard table would be more complex for health insurance than for life insurance, we believe that if Congress decides to impose a tax cap it should change the proposal to be on a coverage basis rather than on a premium basis.

Of course, there are an infinite number of possible coverage configurations in employer provided health coverage. As a practical matter, certain groupings would be necessary. We are confident that ten to twenty groupings could be defined which would accommodate all health plans.

These would be ranked and given a "richness index" based on the actuarial value of the coverage. Furthermore, this index could be adjusted to favor certain cost-effective coverages or delivery systems.

For example, Congress could define a certain level of health coverage which should not be taxed and give it a richness index of 1.00. First dollar hospital and medical surgical coverage would have a richness index of greater than 1.00, and be taxable to some extent, with the level of the index determining the amount of taxable income. A high deductible catastrophic-type coverage would have a richness index of less than 1.00, and not be taxable. Although the coverage itself might suggest a richness index of greater than 1.00, Congress could elect to assign health maintenance organizations, other alternate delivery systems, or outpatient-intensive coverages an index of less than 1.00.

The advantages of this approach are:

1. It is more equitable to the taxpayer.
2. Taxable income is not dependent on the make-up of the employee group or on the funding arrangement.
3. Congress has the flexibility to favor cost-effective coverages or delivery systems.

The purpose of this testimony has been to point out an alternative for taxing employer-provided health coverage. The alternative form has advantages and disadvantages, but on balance, we believe it is better than the current proposal. We hope that if Congress decides to proceed on the health tax cap that it will consider these comments, and we will be happy to meet with the Committee or members of staff if requested.

MARITIME TRADES DEPARTMENT
AMERICAN FEDERATION OF LABOR and CONGRESS OF INDUSTRIAL ORGANIZATIONS
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Seafarers International Union of North America
Sheet Metal Workers International Association
American Federation of State, County and Municipal Employees
United Telegraph Workers
United Textile Workers of America

July 6, 1983

The Honorable Robert Dole
Chairman
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Dole:

On behalf of the Maritime Trades Department, AFL-CIO, and its 8½ million members, I want to express our strong opposition to legislation which would limit tax-free employer contributions to employee health benefit plans. We view this proposal as an inequitable method of raising revenue at the expense of our members who have negotiated decent health insurance coverage for themselves and their families. In addition, it would do nothing to control skyrocketing medical costs while at the same time permitting the needless intrusion of government into the collective bargaining process.

We in the Maritime Trades Department are specifically concerned that the proposed cap will prove discriminatory to our members who are engaged in what are universally considered high risk occupations. Our affiliated unions have members working in ship construction, ship operation, heavy industry, and the building and construction trades. This proposal certainly does not take into account the difference between those workers whose medical costs and health insurance premiums tend to be higher than with those in a job category classified as low risk.

One of the major premises of the tax cap proposal is that it will control ever increasing health care costs. We reject this notion. It is because of soaring medical costs that some of our affiliated unions have passed up scheduled wage increases in order to preserve the health coverage they presently have. Certainly the members of those affected unions would have preferred larger paychecks rather than having to ensure that their present coverage is simply maintained.

This legislative proposal seems to overlook the basic fact that the medical care market place is controlled by those who provide the health care services, not by those who purchase them. Therefore, it is patently unfair to attempt to control health care costs by placing a heavier tax burden on the working men and women of this country. We suggest that the Committee's primary focus should be directed at containing burdensome medical costs without diminishing the level of health care available to the average American worker.

Again, the Maritime Trades Department strongly urges you to reject any legislation of this nature that comes before the Finance Committee for consideration.

Sincerely,

Frank Drozak
President

FD/bc

STATEMENT OF THE
AMERICAN HOTEL & MOTEL ASSOCIATION
ON
TAXATION OF EMPLOYEE HEALTH PLANS
SUBMITTED TO THE
SENATE COMMITTEE ON FINANCE

We are the American Hotel & Motel Association which is a federation of hotel and motel associations located in the fifty states, the District of Columbia, Puerto Rico and the Virgin Islands, having a membership in excess of 8,200 hotels and motels accounting for over one million rentable rooms. Inclusive in our membership are all of the major hotel and motel chains.

As a labor intensive industry, we are particularly concerned about proposals that put a tax cap on employer paid health insurance premiums. This, in the long run, and despite what the proponents say, could be a costly tax proposal for the employer as well as the employee.

The hotel industry is a diverse industry and the majority of our operators are small business people. There are numerous types of management and ownership configurations: large chains, independent franchises, "mom and pop" hotels, motels and inns and we are one of the largest employers of minority workers. One simple tax cap that is supposed to cover all these different type of situations is unfair.

Our industry also has more than its share of tax liability: excise taxes, room taxes, payroll taxes, tip reporting tax information reports and many other taxes which are placing a heavy burden on our industry and notably deterring the expansion of new job opportunities.

Our specific arguments against the tax cap on employer paid health insurance premiums are as follow:

- It would increase employers administrative and payroll costs without any concomitant benefit for employers or employees.

- It would reduce flexibility for employers in bargaining with their employees on various benefits including health benefits. It also would create problems for many of our multi-state employers since health insurance premiums for the same benefit package could vary across the nation.

- The tax cap is a regressive tax. As one of the larger employers of low skilled workers, our workers would be disproportionately effected by such legislation and the resultant taxes would represent a higher portion of family income for low wage earners than for higher paid workers.

- Tax caps are an inefficient way of raising revenue since employers may just shift excess health fringe benefit contributions to other non-taxed fringes.

- It would discourage employers from providing comprehensive health insurance coverage especially in an industry such as ours where employee turnover is high.

- The hotel/motel industry has done much to hire the handicapped. A tax cap would present a disincentive to employers to hire or retain these workers whose predictably higher health care costs drive up insurance costs for all employees in a group. It would also discourage employers from keeping older workers on the payroll.

In summary, the proposal, since it would encourage employers to eliminate or reduce health benefits in an effort to stay below the cap would likely force employers to drop those benefits which encourage long term saving, e.g. preventative health care, out patient benefits, etc. This type of tax is untested and unproven for its ability to raise revenue and it penalizes employers and employees alike. Labor intensive industries such as ours are disproportionately effected by this kind of new tax and more importantly it discourages employers from offering this type of benefit as a normal aspect of good business practices; rather, it treats health care as a special taxable fringe benefit.

American
Psychiatric
Association

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June 27, 1983

The Honrable Robert Dole
Chairman
Senate Committee on Finance
Room SD-221
Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Chairman:

The American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, is pleased to provide our comments on the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income for tax purposes. We request that these comments be made part of the Committee's June 22, 1983, hearing record on this most important subject.

The APA recognizes the Committee's concern that, taken together, so-called employee "fringe benefits" can form a substantial source of in-kind non-taxable income for many people. At the same time, we recognize that these, as wages, are often the end-product of labor negotiations which permit millions of Americans to be more assured of both continued employment and a responsible wage-benefit package. The APA, however, has been deeply concerned about the Administration's plan to single out the employer-paid health insurance premiums for a special "cap" in the name of competition or more responsible health care.

Last year, the Congress adopted as part of TEFRA an increase to five percent in the minimum of adjusted gross income for out-of-pocket health expenditures above which level a tax deduction for health care may be taken on income taxes. Taken together, the TEFRA change and the proposed "health insurance tax cap" represent yet another tragedy for the mentally ill, mentally retarded and handicapped, all of whom are among the most "at risk" for high health care costs. If the health insurance tax cap, as the proposal intends, results in the development of less costly health insurance programs -- the so-called "competition" incentive -- the cost to the mentally ill, retarded and handicapped will be further increased. We know from a recent painful experience with the Federal Employee Health Benefit Program that when benefits must be cut -- and in this case they would be, to reduce premium costs -- the first services to be reduced are those for the very populations we represent or treat. The potential impetus for such health insurance plan changes, generated by employees whose tax status would change with higher premium plans, is tremendous, and history has well instructed us that the voiced or unvoiced concerns of the mentally ill, mentally retarded or disabled are not heeded at such times.

As our patients' and their families' health insurance premiums might be reduced, it would be achieved by focusing in on a cutback in medical benefits for the treatment of mental illness — as documented by recent FEHBP and HMO administrative activity. This would cause greater out-of-pocket expenses which will now not be offset for income tax purposes until such medically necessary expenditures reach an unprecedented five percent of adjusted gross income.

We urge the Committee to consider the veritable Pandora's box it may open before it establishes any changes in the existing tax status for employer-paid health insurance premiums. Other means of raising revenues should be found, rather than to deprive hundreds of individuals of the insurance coverage for their current or potential illnesses.

Sincerely,

Melvin Sabshin MD

Melvin Sabshin, M.D.
Medical Director

MS/TF:mm

STATEMENT

OF THE

AMERICAN OPTOMETRIC ASSOCIATION

TO THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

RE: ADMINISTRATION PROPOSAL TO TAX EMPLOYEE HEALTH INSURANCE BENEFITS

July 8, 1983

American Optometric Association
600 Maryland Avenue, S.W., Suite 400
Washington, D. C. 20024

The American Optometric Association appreciates the opportunity to comment on the Administration proposal to include a portion of employer paid health insurance premiums as taxable income to the employee. AOA is the national organization representing some 23,000 doctors of optometry, optometric educators and students.

The AOA strongly opposes this effort to tax health care coverage of American workers and has serious concerns over the potential consequences of such a shift in tax and health policy. Certainly we share the concern of all Americans over rising health care costs, but believe the Administration proposal offers an overly simplistic approach to a complex problem and could in fact compound the problem.

Two central arguments are offered by the Administration in support of this proposal -- it will contain rising health care costs and produce new revenues for the Treasury. The evidence put forth to support these conclusions is scanty at best, while there is much to suggest that neither of these objectives will be achieved.

Cost Containment

The Administration argues that capping the level of tax free health benefits will expose consumers to the cost of care more directly, resulting in less demand and a lessening of health care inflation.

This premise overlooks the overwhelming contributor to health care inflation -- hospital costs. More than twice as much is spent by Americans each year for hospital care than for physician services, dental, vision and other services combined, and the cost of hospitalization has been increasing at a yearly rate far above the increases in both the Consumer Price Index and other health related expenditures. The Administration cap levels of $175 a month for a family and $70 for an individual will do virtually nothing to address this problem. To suggest that employee benefit plans will reduce the level of hospitalization coverage as a result of the cap level ignores the history of labor-management negotiations as well as studies which consistently show that workers want the most comprehensive protections from the threat of high hospital costs. Thus, the likely result of imposing the cap levels will be a maintenance of hospitalization coverage and an abandonment of essential, cost-effective preventive care services such as vision, dental, mental health, drug and alcohol abuse. The elimination of these benefits will do nothing to reduce the primary cause of spiraling health care costs, hospital care, and may indeed have just the opposite effect.

The Rand Corporation has studied the concept of taxing health care benefits and concluded in a report released in February of this year that lowered utilization of preventive services as a result of a tax cap could "adversely affect the health status of employees and dependents."

Increased Revenues

Estimates provided by the Administration indicate that the proposal will raise more than $2 billion in new revenues. In making these projections, however, the Administration gave no consideration to the strong possibility that employers will restructure their employee benefit plans to maintain health insurance premiums under the cap level and shift the difference into non-taxable benefit areas. Virtually all labor and business groups who have commented on this proposal have indicated such a shift of benefits is almost a certainty. Thus, the estimates for increased revenues are highly questionable.

While the tax cap is not likely to contain health care costs and raise revenues, it will succeed in penalizing certain groups of workers. Among those groups likely to be adversely affected by the proposal are:

Older workers who use the health care delivery system more frequently than younger workers. Groups with a larger than average number of older workers will have higher premium costs.

High risk occupation workers who are typically charged higher premiums because of the hazardous nature of their jobs.

Workers in areas of the country where health care costs are higher than average.

The rising cost of health care is indeed a serious and growing national problem. It deserves a careful and thorough attention that the AOA believes is lacking in the tax cap proposal. AOA firmly believes that the proposal will not produce the intended result of cost containment and increased revenues, but in fact will unfairly discriminate against certain groups of workers and adversely affect the health of workers by lessening the availability of cost-effective preventive services.

Charles Phelps, PhD., an economist for the Rand Corporation, concluded in a study published by the American Enterprise Institute that "Increased taxation of health insurance policies poses grave uncertainties in outcomes. Casual choices for complex tax issues likely will introduce important unforseen complications into both the tax law and the functioning of medical markets. Caution and further analysis will pay large dividends." The American Optometric Association strongly supports that advice in approaching this important issue.

Statement of
The Associated General Contractors of America
on the Topic of
Employer-Provided Medical Care and Fringe Benefits Taxation
Presented to the
Senate Finance Committee
July 14, 1983

AGC is:

- More than 32,000 firms including 8,500 of America's leading general contracting firms responsible for the employment of 3,400,000-plus employees;
- 112 chapters nationwide;
- More than 80% of America's contract construction of commercial buildings, highways, industrial and municipal-utility facilities;
- Over $100 billion of construction volume annually.

The Associated General Contractors of America (AGC) represents more than 32,000 firms including 8,500 of America's leading general contracting companies which are responsible for the employment of more than 3,400,000 individuals. These member contractors perform more than 80% of America's contract construction of commercial buildings, highways, industrial and municipal-utility facilities. AGC members also perform approximately 50 percent of the contract construction performed by American firms abroad. We appreciate the opportunity to submit written testimony regarding the limited taxation of employer provided medical care and on the general subject of the taxation of fringe benefits.

Employer-Provided Medical Care

AGC supports the long established national policy of excluding employer-provided medical care from taxation at the employee level while allowing employers to deduct the cost of such care as a business expense. The traditional justification for treating health benefits as a nontaxable benefit is as sound today as it has been in the past. Employer-paid medical care benefits assure that employees will seek health care as needed, encourages cost efficient preventive health care, and gives employees the security of knowing that if a health problem arises they will not be economically disadvantaged.

The national policy has always allowed employers, and in the case of unionized workers, employers and employees through the process of free collective bargaining, to decide on the level of coverage which should be provided. There is no reason to change this policy now. In addition it is important to keep in mind that the cost of providing benefits varies in each part of the country and the level of benefits desired or needed by the various groups of employees also varies. A uniform national cap on the maximum excludable benefit will result in a lower level of health care in high cost areas and generally restrict the coverage of benefits such as dental care and preventive treatment.

In addition to opposing the imposition of income taxes on employees for any portion of employer-provided medical care we are opposed to subjecting such benefits to either social security (FICA) or unemployment (FUTA) taxes. Social security and unemployment benefits are designed to provide important benefits to workers based on wage levels. Health care benefits have never been considered as part of the wage base. Privately provided health benefits complement public social programs and are significantly more efficient programs for providing benefits. The imposition of either FICA or FUTA taxes on these benefit programs will only restrict the more efficient private programs in favor of less efficient public programs. In addition to these general policy considerations, unique administrative problems are associated with the taxation of health care benefits provided under multi employer plans commonly found in the construction industry.

Multi Employer Plans

The construction industry in the United States is characterized by thousands of small highly competitive firms. An individual firm has varying labor requirements depending on the number and type of projects it is performing. Electricians, plumbers, plasterers, masons, carpenters and a variety of other skilled tradespersons often work for several firms in a single month. In addition, both employers and employees must be geographically mobile due to the inherent changes in work sites necessitated by construction.

The unique nature of employment in the construction industry has lead to the creation of multi employer plans. These plans, which are maintained pursuant to collective bargaining agreements, cover millions of construction employees and receive contributions from thousands of construction employers. They have proven most effective for providing health-care coverage for construction workers given the high turnover, geographic mobility, and seasonality of the construction industry. They provide the only practical method for providing benefits to construction workers, who because of the nature of the industry, often are employed by numerous construction employers in a single year.

Generally, these plans function in a manner which leaves all day-to-day administration, record keeping, and paper work to the plan itself. Covered employees' claims for benefits are filed directly with the plan and the employers' only responsibility is to make the agreed-to contributions. This administrative function of the plan is a significant and key factor to their effectiveness and efficiency in providing benefits to employees.

Prior imposition of FICA taxes on benefits provided by multi employer plans has lead to a highly inequitable distribution of the tax liabilities among employers when the plans have not chosen to be designated as the "employer" as permitted by P.L. 97-123. The majority of plans in the United States have not elected to pass on either paper work or FICA tax liabilities. Rather, when paying disability payments plans have chosen to be designated as the "employer" for purposes of informational filing and tax liability. Unfortunately a minority of plans who have not chosen to be designated as the "employer" for these benefit functions have caused employers significant administrative burdens never contemplated in the function of multi employer plans. As a result, AGC urges that multi employer plans be designated as the employer for the purposes of administrative functions and payment of FICA and FUTA taxes associated with the payment of benefits by those plans pursuant to a collective bargaining agreement. The effective date provisions of S 640 properly delay the effective date of the statute to allow the collective bargaining process to adjust for this process.

While the legislative proposal includes a special provision for multiemployer plans which is a recognition of their unique nature, we are concerned that these special rules will still result in an inequitable distribution of the tax liability and additional administrative problems for contributory employers. The resultant paper work required of each employer will be significant and undermine one of the principal advantages of multiemployer plans in the construction industry -- centralized administrative functions. We are also of the opinion that the endless paper trail created by such rules will prove to be unauditable by the IRS.

The formula for allocating liability for employer-provided health care is based on a percentage of the employer's contributions to the multiemployer plan. It is important to understand that the contributions received by multi employer plans are utilized to provide two types of additional coverage which significantly affect cost. Employer contributions are utilized not only to fund the health care coverage of "employees", but are often used to provide health care coverage for retirees. More important, the same contributions on behalf of working covered "employees" often are used to provide coverage for workers during periods of unemployment. As a result, any calculation of the amount contributed on an employee's behalf for purposes of the cap must be adjusted to take into account these extra benefits provided out of an employer's contributions. The current allocation formula included for multiemployer plans fails to recognize these additional costs.

Fringe Benefit Taxation

The current moratorium on the issuance of regulations by the Internal Revenue Service covering the taxation of non-statutory fringe benefits should be extended. The current proposals of the Treasury Department of either disallowing business deductions for the cost of benefits or imposing an excise tax on the employer on the value of the benefits are totally inappropriate and should be rejected by Congress. The cost of providing benefits are necessary business expenses under Section 162 of the Internal Revenue Code.

ASSOCIATION OF FLIGHT ATTENDANTS AFL-CIO
1625 MASSACHUSETTS AVENUE, N.W., WASHINGTON, D.C. 20036 202-328-5400

July 1, 1983

The Honorable Robert Dole
Chairman, Senate Finance Committee
United States Senate
SD-207 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The Association of Flight Attendants (AFA), representing 21,000 flight attendants on 14 airlines, appreciates this opportunity to comment on the Administration's proposed taxation of certain fringe benefits.

Specifically, we strongly oppose 1) the proposal to limit the tax-free amount of employer contributions to employee health insurance, and 2) any new taxation of the travel pass benefits historically granted to airline employees.

Taxation of Employer Contributions to Health Insurance

The Administration's 1984 budget proposes that employer-paid health insurance premiums above $175/month per family or $70/month per employee be included in the employee's taxable income.

We strongly object to this taxation of health benefits for the following reasons:

The proposal is based on the erroneous premise that health care costs will shrink because people will become more cost-conscious and use less health care if they are forced to pay a larger share of its cost.

In fact, if the tax is approved, the first pieces of the health insurance to be scrapped will be those covering preventive care -- outpatient, dental, vision, and mental health -- all of which are cost effective. In addition, the tax would encourage people to delay obtaining treatment at the early stages of an illness or injury, thus ultimately increasing the cost of treatment when an illness becomes more severe.

Employees already "pay" for their health benefits. Since the cost of a health plan is included as part of their total compensation package, employees forego other compensation or benefits when they accept employer-paid health benefits.

The proposed tax undermines the basic concept of health insurance -- to prevent severe financial loss in the event of illness or injury -- by forcing most individuals to choose the least expensive coverage, regardless of the adequacy of the plan for their health needs. The tax would penalize older workers, those with chronic conditions, pregnant women, and families with children, who require more medical services.

The proposed limit on non-taxable monthly contributions fails to account for regional variation in the cost of health care. A plan costing $70/month might provide a reasonable level of service to a resident of Arkansas, but would buy woefully inadequate coverage for a resident of a high cost area such as New York City.

A new tax treatment of health benefits would create a nightmare in labor relations, by requiring the reopening of collective bargaining agreements to reassess the total compensation package.

Finally, the tax proposal assumes that people deliberately overutilize costly health services because their health insurance picks up the tab for them. In fact, people usually do not choose to be ill, nor do people usually choose their own course of treatment, but instead rely on the expertise of physicians who prescribe appropriate health care for them. Thus while the proposed tax might unfortunately encourage people to delay seeking treatment or to avoid preventive care, the tax would not curb the utilization of vastly more expensive hospital and surgical services.

In short, the proposal will place an additional tax on benefits which workers have already paid for, it will reduce the health standards of the population, and ultimately will not reduce the cost of health care.

Taxation of Airline Pass Benefits

The AFA strongly opposes the inclusion as taxable income of the reduced rate travel benefits historically granted to airline employees and their dependents.

Currently, the taxation of such pass benefits is prohibited by a Congressional moratorium on the issuance of IRS regulations relating to the tax treatment of fringe benefits. This moratorium expires December 31, 1983. AFA urges Congress to codify the long-established practice of exempting from taxable income the travel benefits of airline workers and their families.

Airline employee pass benefits should remain tax-exempt for several reasons:

The benefit represents a negligible cost to the company. The passes may be used only on a restricted, space-available basis. Typically, an employee may use the pass only if the plane has an empty seat; he or she cannot displace a fare-paying passenger.

Contrary to popular belief, the pass is not "free"; there is a cost incurred with all passes although it is at a substantial reduction from regular fares. This in itself presents an administrative problem for taxing passes. How does one determine the value of a pass that is granted only if space is available? How much is a flight worth when the airline employee may have to wait as long as 48 hours to get an open flight? The employee may have to suffer substantial inconvenience in order to take advantage of this benefit, which may be restricted to specific times and geographical areas. How does one assign a dollar value to a travel pass when revenue passengers on the same flight have paid a dozen different ticket prices depending on which discount or promotion was in effect at the time of their ticket purchases? Because of the wide variation in company policies and utilization of pass benefits, the inequities of any program designed to tax this benefit seem overwhelming.

Taxing this benefit would place a severe hardship on many of our "commuter" members who must fly between their home cities and their flying jobs. Because of the disruptions caused by deregulation, these people have been transferred to different bases as the airlines change route structures and close old bases. These employees may be transferred only temporarily, or they may be unable to relocate in the new base city. In these cases their passes enable them to "commute" by air to their jobs. Our more than 1,000 commuter members could not afford to pay for this transportation. Taxing this critical means of livelihood would be grossly unfair. Taxing space-available employee passes while airlines "give away" tax-free reserved seats to passengers under "mileage plus" programs would be an added injustice.

The Treasury Department itself has argued against taxing airline passes. Its 1975 "discussion draft" on fringe benefit taxation included a general rule that employees do not receive taxable compensation when the benefit is available anyway (such as an empty airline seat), when it costs the employer nothing to provide, and when it is available to all employees on a non-discriminatory basis. According to the Treasury Department, airline employee travel passes met these criteria for non-taxable benefits.

The bulk of airline passengers are flight attendants, mechanics, clerks, and fleet service workers. They are hard working middle-income career people, who already bear their full share of the nation's tax burden. Placing additional taxes on their pass benefits, or their health insurance benefits are ill-conceived notions which lack equity, and administrative ease, and which would be detrimental to our members' standards of health care and working life. We urge your opposition to these proposals.

Sincerely,

Linda Puchala

Linda A. Puchala
President

LAP/clk

FROM: Blue Cross and Blue Shield Association
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Washington, D.C. 20006

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June 22, 1983

TAX CAP ON HEALTH INSURANCE
"POOR PUBLIC POLICY"

(WASHINGTON)--Calling the proposal to cap the tax exemption on employer-paid health insurance premiums "poor public policy," Bernard R. Tresnowski, president of the Blue Cross and Blue Shield Association, said, "We believe such a tax would result in little or no overall health care savings and would do little to raise revenues."

Testifying before the Senate Finance Committee today, Tresnowski pointed out that a tax cap would adversely affect the aged, sick, and disabled and would hit lower income workers disproportionately hard.

Noting that both employees and employers might react to a tax cap by substituting other non-taxable fringe benefits for health insurance benefits costing more than the amount of the cap, Tresnowski said the actual revenues produced from the tax cap would be far less than projected.

More importantly, he noted, any revenues produced from a tax cap "would be largely derived from those who are among the more vulnerable in our society -- the older, sick or disabled workers and their families who because of their perceived medical needs choose more comprehensive health coverage."

Because their premiums will be higher, groups that include such employees will pay more taxes than healthier groups. In these cases, employer costs would also increase because premium contributions above the cap would be subject to payroll taxes.

He also cited studies conducted at the National Center for Health Services Research showing that workers who earn less than $10,000 a year could be paying additional taxes of $85, or 1.4 per cent of their income as a result of the tax cap. Workers earning more than $50,000 per year would be paying $227 additional, but it would represent only 0.3 per cent of their income.

Requiring employees to pay taxes on insurance premiums above the cap could also lead to erosion of a basic health insurance principle, Tresnowski said -- the principle of spreading the cost of illness over the sick and healthy, thus spreading the risks. If employees are offered a choice, the healthier ones will choose a low cost health insurance plan, leaving the older, less healthy workers in the more comprehensive, high cost plan. Over time, the cost of providing services to the high users of services will lead to higher premiums and the loss of more of the younger, healtheir employees to help share the costs.

"Abruptly imposing a limit on employer-based insurance may result in elimination of or reduced coverage for those benefits which have a lower cost per unit of service such as preventive care, outpatient physician services and home health care," the Blue Cross and Blue Shield Association chief pointed out.

Given a choice, employees will retain maximum coverage for hospital inpatient care. "Yet it is expanded coverage for selected outpatient, lower cost services which appears to be effective in containing costs over the long-term," Tresnowski said. He cited a recent study by the Johns Hopkins University which indicated that increased coverage of outpatient care by Blue Cross and Blue Shield Plans and the substitution of those services for expensive inpatient care had contributed to a steady decline in Blue Cross inpatient admissions at a time when the inpatient admission rates for the general population under 65 were rising.

Tresnowski also pointed out that the tax cap would introduce a host of new complications for employers. In particular, employers with facilities in different areas may find it extremely difficult to assure equal benefits throughout their company because premiums, and therefore the taxes, can vary dramatically across the nation and between urban and rural areas.

In conclusion, he noted that while the Administration has claimed that it does not wish to raise taxes, such a cap "is clearly a new tax on working Americans."

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DELTA DENTAL PLANS ASSOCIATION
ERIK D. OLSEN, D.D.S., PRESIDENT
STATEMENT ON S.640
SUBMITTED TO THE
COMMITTEE ON FINANCE
JUNE 22, 1983

Delta Dental Plans, which presently covers more than 15 million dental beneficiaries opposes the bill S.640 that would impose by law a maximum dollar amount on non-taxable health care benefits of American workers. A number of reasons we have for believing S.640 harmful legislation are held in common with many other individuals and organizations who oppose it. These include:

--the probability that little if any revenue would result from its enactment since there would be a swift readjustment of available benefits dollars from health care to other areas;

--the belief that such a movement away from health care benefits would partially destroy the private sector effort, long urged upon it by many federal officials and Members of Congress, to provide workers with broadly-based health care plans;

--the unequal burden that would fall upon workers in various sectors of the country because of significantly differing costs of living, including health care premiums, and

--the inappropriateness of singling out health care necessary to the basic protection of the lowest income workers, as the first fringe benefit to be taxed.

In addition, those of us involved in providing group dental prepayment have special reasons both for concern and for opposition. It is our belief that S.640 would prove especially harmful to dental insurance; clearly, our purely selfish interests are, then, involved. That selfishness is somewhat moderated, perhaps, by the conviction that the total health of the American people is better today, when more than 80 million people have dental insurance programs, than it was 20 years ago when it was all but non-existent. While various statistics can be offered to document this belief, one brief example might suffice here as illustration: extrapolating from a study done in the Hartford area, University of Connecticut researchers speculate that as many as 48 million work days are lost annually in American industry because of "acute dental conditions." Clearly, dental insurance is not a luxury item.

Moreover, we believe that our fears that passage of S.640 will cause significant adverse consequences are supported by reason, logic and the November 1982 Rand study on health care costs. This is the same study that is often referred to by proponents of the health tax as an efficacious method of reducing overall health care costs. The heart of our opposition to S.640 is that it would not necessarily reduce overall health expenditures by increasing consumer awareness through increased co-payments and deductibles but could have just the opposite effect.

> According to the study...(p)eople would probably not reduce their insurance coverage uniformly but would follow some simple principles in making selective reductions. Just as insurance was historically first chosen to cover the highest risk services(e.g., hospitalization) and only later extended to cover lower risk services (e.g., physician office visits

> dental care, psychiatric visits), retrenchment in coverage would probably follow similar patterns. Dental care, ambulatory care, drugs, and similar services would probably become uncovered or, at least, covered only with very large yearly deductibles of perhaps $500 or more, rather than currently typical deductibles of $150 to $200. In terms of effects on aggregate medical care market demand, most purchases of these services would be uninsured. Hospital insurance coverage would probably be least changed, because the financial risks are greatest for hospitalization. (Health Care Costs-The Consequences of Increased Cost Sharing, Charles E. Phelps, November 1982, The Rand Corporation, page 17-18).

It is thus in the area of preventive services that the largest reductions would be made - the very services designed to reduce costly hospital stays. We would like to suggest that, if the fundamental purpose of this legislation is to introduce reforms into health care insurance that will result in cost savings because of intensified consumer consciousness, we believe dental insurance has largely accomplished much of what is being sought. If this is true, it seems patently unfair for our industry to be penalized for having done over the past thirty years what Congress seeks to have other sectors of health to begin doing now.

The typical group dental prepayment program offered by Delta Plans -- as well as by most of the commercial insurance companies -- has a series of structured components that force the consumer-patient to weigh the consequences of care. Without attempting to describe them in detail, I would list such commonplace features as deductibles; co-payments often as high as 50% and, with respect to orthodontic care, frequently higher; annual maximums and exclusions. The typical Delta Dental subscriber pays approximately 30% of incurred covered expenses as well as paying for excluded services and often the total cost of orthodontic care since many plans treat it as an excluded service.

In addition, the Delta system has a participating dentist structure which requires pre-filing of fees and allows Delta to reject fees that are excessive. In our view, this system is one explanation for the way dental fees, as measured by the CPI, have lagged considerably behind the other components of the medical care item of the CPI.

A final feature that is invariably part of a Delta contract is the right to reimburse the dentist at the lower of two fees when, in the professional opinion of our consultants, either service is professionally acceptable for the condititon. Participating dentists may not, under our contractual agreement, attempt to collect additional sums from the patient for covered services. The provisions described in the above paragraphs have, as a totality, made dental prepayment a cost-effective service in which the beneficiary shares payment to a significant degree.

We think this arrangement better achieves to a great extent all of the cost containment goals that are embodied in S.640. We think this record deserves careful review on its own; we think it has some significance for the way in which health care insurance can be shaped in the future. We believe it would be vastly more effective in the long run than S.640.

Attached to our statement is a table -- which we ask be made a part of this record -- that clearly shows dental fees have stayed consistantly below the other elements of the medical care item of the Consumer Price Index.

On behalf, then, of Delta Dental Plans Association, we urge that the committee reject S.640.

CONSUMER PRICE INDEX, U.S. AVERAGES FOR SELECTED ITEMS

AVERAGE ANNUAL INDEX (1967 = 100)

Year	Dental services	Physician services	Hospital room	Medical care	Services	All items
1970	119.4	121.4	145.4	120.6	121.6	116.3
1971	127.0	129.8	163.1	128.4	128.4	121.3
1972	132.3	133.8	173.9	132.5	133.3	125.3
1973	136.4	138.2	182.1	137.7	139.1	133.1
1974	146.8	150.9	201.5	150.5	152.1	147.7
1975	161.9	169.4	236.1	168.6	166.6	161.2
1976	172.2	188.5	268.6	184.7	180.4	170.5
1977	185.1	206.0	299.5	202.4	194.3	181.5
1978	198.1	223.1	332.4	219.4	210.9	195.4
1979	214.8	243.6	370.3	239.7	234.2	217.4
1980	240.2	269.3	418.9	265.9	270.3	246.8
1981	263.3	299.0	481.1	294.6	318.2	272.4
1982	283.6	327.1	556.6	328.7	356.0	289.1
% increase 1970-82	137.5	169.4	282.8	172.6	192.8	148.6

Source: U.S. Department of Labor
Consumer Price Index for All
Urban Consumers

★ FARM BUREAU ★
★★the nation's largest general farm organization★★

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION
TO THE SENATE FINANCE COMMITTEE
REGARDING THE ADMINISTRATION'S PROPOSAL
TO TAX A PORTION OF EMPLOYER-FINANCED HEALTH INSURANCE

June 22, 1983

-- SUMMARY --

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION TO THE SENATE FINANCE COMMITTEE REGARDING THE ADMINISTRATION'S PROPOSAL TO TAX A PORTION OF EMPLOYER-FINANCED HEALTH INSURANCE

June 22, 1983

Farm Bureau opposes the Administration's budget proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income. Farm Bureau views this proposal as the imposition of a new tax to contain health care costs and reduce the deficit. We fail to see how more taxes on health consumers will cause doctors, hospitals, and other health care providers to cut costs. Farm Bureau supports reducing the deficit, but Congress and the Administration continue to look toward higher taxes rather than lower spending to reduce the deficit. We urge the Committee to reject the Administration's proposal.

The proposed cap on tax-free health insurance premiums focuses attention on a related health insurance matter--the inequity that exists in the use of income tax deductions to subsidize health insurance. For instance, many employers furnish health insurance for their employees. The full cost of the coverage is deductible to the employer as a business expense (IRC 162) and is tax free to the employee (IRC 106). The federal government is subsidizing health care for these taxpayers at the expense of two other groups of taxpayers who cannot take advantage of these tax code provisions: (1) self-employed taxpayers and, (2) employees who do not receive employer-financed health insurance coverage.

From the standpoint of self-employed farmers, there is a question of the equity of differential tax treatment for similarly situated farmers. A self-employed farmer (sole proprietor) cannot deduct the cost of health insurance premiums as a business expense. If the farming operation were incorporated, however, the farmer would be classified as an employee of the farming corporation. The corporation, as the employer, could then deduct the cost of the health insurance as a corporate business expense; and the farmer, as the employee, could receive the health insurance tax-free.

The other group of taxpayers who do not receive fair treatment under current tax provisions for health insurance coverage are employees who must buy their own health insurance. An employee or self-employed taxpayer who has to purchase his or her own insurance cannot purchase the same amount of coverage with after-tax dollars as inexpensively as an employer can furnish it to employees.

Farm Bureau urges the Senate Finance Committee to consider these alternatives to erase the inequity that exists in the tax treatment of health insurance premiums: (1) a business deduction for the cost of a self-employed taxpayer's health insurance, or (2) a personal deduction or credit for any individual's health care insurance regardless of whether deductions are itemized.

The Administration's cap proposal should be rejected because it is actually another tax increase.

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION TO THE SENATE FINANCE COMMITTEE REGARDING THE ADMINISTRATION'S PROPOSAL TO TAX A PORTION OF EMPLOYER-FINANCED HEALTH INSURANCE

June 22, 1983

Farm Bureau is the nation's largest agricultural organization representing farmers and ranchers in forty-eight states and Puerto Rico. Our policy is the result of a comprehensive policy development program at the county, state, and national levels that involves the active participation of our producer members.

Over three million member families belong to the Farm Bureau. Their livelihood is primarily in agriculture, but their interests extend to other areas such as tax, budget, and health care issues. These issues affect the economic well-being of farmers and ranchers. For this reason Farm Bureau is pleased to comment on the Administration's proposal to tax a portion of health insurance premiums paid by employers. Farm Bureau members may be employers, employees, or self-employed, but, regardless of their employment status, they are all affected by the Administration's plan to impose another tax on the public.

FARM BUREAU POSITION ON THE ADMINISTRATION'S PROPOSAL

The American Farm Bureau Federation opposes the Administration's budget proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income. Specifically, the proposal would treat as taxable income any amount contributed by the employer for the employee's health insurance that annually exceeds $840 per individual or $2,100 per family plan.

While the Administration's rationale for this proposal is that employees would become more conscious of health care costs and that it would enhance cost containment, Farm Bureau views it as another Administration revenue-raising measure--a tax. In fact, Office of Management and Budget Director David Stockman has already suggested that the proposed cap levels be decreased to attribute more taxable income to employees and, therefore, more revenues to the Treasury. He has suggested that the extra money be used to finance health insurance for the unemployed. Mr. Stockman's comments indicate that the Administration is indeed considering the cap as a "revenue enhancer," not just a cost containment measure.

Our members do not consider the taxation of employer-financed health insurance premiums to be the most appropriate way to cut health care costs or to reduce the deficit. We fail to see how more taxes on health consumers will cause doctors, hospitals, and other providers to cut health care costs. The latter goal of reducing the deficit is laudable and supported by Farm Bureau, but Congress and the Administration continue to look toward higher taxes rather than lower spending to reduce the deficit.

Farm Bureau urges the Senate Finance Committee to reject the Administration's proposal to tax employees' health insurance benefits. A nearly unbearable tax burden on the middle-income class has already prompted the growth of a large underground economy that defies taxation. A new tax will neither stem health care costs nor address the real reason behind high deficits: increased federal spending the hallmark of which is uncontrollable entitlement programs. Until Members of Congress resolve to tackle the entitlement programs, our economy will continue to be plagued by high health care costs, heavy taxes, and an increasing deficit.

INEQUITABLE TAX TREATMENT OF THOSE WHO SELF-FINANCE THEIR HEALTH INSURANCE

The proposed cap on tax-free health insurance premiums focuses attention on a related health insurance matter--the inequity that exists in the use of income tax deductions to subsidize health insurance. For instance, many employers furnish health insurance coverage for their employees. The full cost of the coverage is deductible to the employer as a business expense (IRC 162) and is tax free to the employee (IRC 106). The federal government is subsidizing health care for these taxpayers at the expense of two other groups of taxpayers who cannot take advantage of these tax code provisions: (1) self-employed taxpayers and, (2) employees who do not receive employer-financed health insurance coverage.

SELF-EMPLOYED TAXPAYERS

Farmers constitute a significant percentage of self-employed individuals (14 percent). The most recent figures given to us by the Internal Revenue Service indicate that in 1978 there were 1.1 million farmers out of a total of approximately 7.6 million self-employed people.

A business deduction is not available to self-employed farmers for the cost of their health insurance. The denial of a business deduction is apparently because the insurance is considered a personal expense rather than a business expense. This is short-sighted reasoning. A self-employed person has a hybrid business and employment situation, conducting business activities both as an employer and an employee. Therefore, a self-employed person should be able to deduct his or her insurance premium as a business expense under IRC Section 162 without regard to the limit for itemized deductions in Section 213. Presently, the only way a self-employed individual can deduct any amount of health insurance costs is if the premium is included as an itemized medical expense and constitutes more than five percent of adjusted gross income (IRC 213).

From the standpoint of self-employed farmers, there is a question of the equity of differential tax treatment for similarly situated farmers. For example, a self-employed farmer (sole proprietor) cannot deduct the cost of health insurance premiums as a business expense.

If the farming operation were incorporated, however, the farmer would be classified as an employee of the farming corporation. The corporation, as the employer, could then deduct the cost of the health insurance as a corporate business expense; and the farmer, as the employee, could receive the health insurance tax free.

The type of a farm business organization--sole proprietorship, partnership, or corporation--determines the type of tax treatment of the farming operation. The effect of differential tax treatment could cause a farmer to consider incorporation when other business and personal factors might dictate otherwise. Farming has become an increasingly expensive business. Farmers must have access to business deductions regardless of the form of business organization they choose. The prospect of additional taxes in the next few years will take an increasing amount of money out of farmers' pockets. An income tax deduction for health insurance costs is a justifiable business expense because of the hybrid nature of self-employment.

EMPLOYEE TAXPAYERS WHO DO NOT RECEIVE EMPLOYER-FINANCED HEALTH CARE INSURANCE

The other group of taxpayers who do not receive fair treatment under current tax provisions for health insurance coverage are employees who must buy their own health insurance. An employee or self-employed taxpayer who has to purchase his or her own insurance cannot purchase the same amount of coverage with after-tax dollars as inexpensively as an employer can furnish it to employees. Simply put, the federal government is subsidizing health care at the expense of self-employed people and employees who do not receive employer-financed coverage.

FARM BUREAU POSITION ON EMPLOYER-FINANCED HEALTH CARE

At the 64th annual meeting of the American Farm Bureau Federation, voting delegates adopted the following policy--

> "We support legislation to allow federal income tax credits or tax deductions for those who self-finance their health insurance."

We urge the Senate Finance Committee to consider these alternatives to erase the inequity that exists in the tax treatment of health insurance premiums: (1) a business deduction for the cost of a self-employed taxpayer's health insurance, or (2) a personal deduction or credit for any individual's health care insurance regardless of whether deductions are itemized. This alternative would help taxpayers who do not itemize, but who must pay the high cost of health insurance out of their own pockets.

Even if Congress caps a portion of employer-financed health insurance, the inequity would still exist. Those employees whose health insurance premiums are paid by their employers would continue to receive a certain level of coverage (up to $840 or $2,100 in premiums) tax-free since the premiums would fall below these cap amounts. Individuals who self-finance their health insurance would have to continue to pay their premiums with after-tax dollars. For example, a typical case of the health insurance costs of a self-employed farmer and his wife (ages 61 and 59 respectively) reveals a 1983 annual approximate cost of $2,480.00 based upon a quarterly premium of $620.00. In 1981 identical coverage cost $1,184.00 based upon a quarterly premium of $296.00. (Arkansas Blue Cross/Blue Shield Comprehensive Major Medical Group Subscriber--Family Plan, $300 Deductible). Even with a $2,100 cap, employees who receive identical employer-financed coverage would receive most of the coverage tax free.

Attached to this statement are examples of quarterly Blue Cross/Blue Shield premiums for Farm Bureau members in Kansas and Michigan. The costs will "knock you off your feet." In addition to the exorbitant insurance costs, it is ironic that taxpayers no longer have benefit of the $150 deduction for health insurance premiums.

The concept of a deduction or credit for the cost of health insurance premiums could be patterned after the deductions/credits enacted in the Social Security Reform Act of 1983. Despite the recent Social Security tax increase, the new law took a step to help offset the burden of higher Social Security taxes. The new law provides that self-employed individuals will be able to take a tax credit for 1984 - 1989 against the self-employment tax that they must pay. After 1990, a new system of income tax deductions will be available to self-employed taxpayers. The deduction will be equal to one half of the amount of self-employment taxes paid for the taxable year. Farm Bureau believes that this type of system could be applied to reduce a self-employed person's health insurance costs.

Congress is addressing the issue of health care insurance for the unemployed. The employed, as well as the unemployed, are hurt by rising health care costs. A deduction or credit could reduce the burden, not only of higher health costs, but of the increasing tax load on the middle-income taxpayer.

Farm Bureau urges the Committee to oppose the Administration's proposed cap because it is a tax increase, and to expand, rather than restrict, the benefits surrounding the tax treatment of health insurance premiums. To do so is a matter of equity.

Thank you for the opportunity to comment on these health insurance issues.

Appendix

KANSAS FARM BUREAU GROUP
BLUE CROSS - BLUE SHIELD

Selected Premium Examples
Based on Age
($300 Deductible Single Plan--$600 Deductible Family Plan)

AGE CATEGORY	QUARTERLY PREMIUM PAID	
	SINGLE	FAMILY
Less than 30	$ 68.04	$157.27
30-34	79.65	171.64
35-39	89.14	182.72
40-44	99.75	194.51
45-49	111.63	207.05
50-54	124.92	220.39
55-59	139.79	234.62
60-64	156.44	249.75

MICHIGAN FARM BUREAU GROUP
BLUE CROSS - BLUE SHIELD

Selected Premium Examples
Based on Age and Area Ratings
($0 Deductible - Family Plan)

-- COMPREHENSIVE COVERAGE - OUTSTATE --

AGE CATEGORY	QUARTERLY PREMIUM PAID
Under 45	$475.53
45-54	$706.77
55-64	$779.37
65 & over	$306.03--2 person complimentary (Supplemental policy for Medicare participants)

-- COMPREHENSIVE COVERAGE - METROPOLITAN --

AGE CATEGORY	QUARTERLY PREMIUM PAID
Under 45	$637.65
45-54	$947.61
55-64	$1,045.02
65 & over	$356.58--2 person complimentary (Supplemental policy for Medicare participants)

group Health association of america, inc.

July 6, 1983

The Honorable Robert Dole
Chairman
Committee on Finance
United States Senate
SD-221 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Dole:

On June 22, 1983, the Senate Finance Committee conducted a hearing on the Administration's proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income (S. 640). We would like to request that the following brief statement be included in the hearing record.

As the major representative of HMOs in the country, we wish to express our serious apprehension that "tax caps" or related measures may damage the ability of HMOs to compete in the market and therefore hinder their continued growth and development. Further, we are concerned about the ultimate effect of the tax cap change on access to health care generally.

The Health Maintenance Organization development strategy pursued by the last four Administrations and Congress has been premised on support for the concept of reasonably comprehensive benefits delivered in an efficient and cost effective manner. The provision of comprehensive care through an organized system with judicious use of copayments was intended to have and has had the immediate effect of maximizing the value of the health care dollar of HMO members and the longer range effect of containing costs through increased competition in the marketplace.

The strategy has worked well. Studies by public and private agencies demonstrate that the presence of HMOs in a community can have a restraining effect on health care costs in that community. Of equal significance are recent studies and surveys which show an overwhelming acceptance of HMOs by those currently enrolled. With the current rate of HMO enrollment growth at an approximate annual rate of twelve percent, we can safely assume that the public will join cost effective systems and will be satisfied with the health care received.

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James F. Doherty

The proposed tax caps would tend to slow or halt this positive trend. As employers and employees respond to the incentive to opt for the tax advantages of low premium, limited benefit programs, HMOs offering comprehensive benefits are likely to be subject to adverse selection (extraordinary enrollment of high risks or the inability to enroll low risks) with a consequent inflation of premiums and decline in total membership. We anticipate that many of the smaller, newly developed HMOs will not have the financial stamina to survive. Attached is an article on a relevant experience at the Group Health Cooperative of Puget Sound. This experience demonstrates that higher HMO premiums result in rather dramatic adverse selection.

We are aware that the preliminary results of the Rand study released last year suggest that higher out of pocket payments tend to reduce utilization. The critics of the study feel the conclusion may be short term, because beneficiaries may be delaying needed care causing greater costs in the long run. In any event, the study is ongoing and lacks the certainty on which to base a legislative proposal which will substantially alter national health care reimbursement policies. It would be a tragedy if the enactment of a tax cap were to discourage access to necessary care for large groups of Americans.

In addition, enactment of a tax cap may undermine a national HMO strategy which is proving successful within its first decade of implementation. Since 1973, HMO membership has increased fourfold to 11 million, and the number of HMOs in the nation has increased sevenfold. The federal financial assistance program is being phased out after having served two important purposes. By demonstrating the strength of the federal commitment to the development of cost-effective systems, it fostered the establishment of new HMOs and the growth of existing plans, and it measurably increased public awareness of HMOs as an alternative to the traditional fee-for-service system.

With this kind of encouragement, private investment in HMOs has grown steadily throughout the last decade, and almost all HMOs are self-supporting. Organized providers have substantially lessened their opposition, and over sixty thousand physicians have relationships with one or more HMOs.

Finally, this organization is quite sympathetic to your efforts to contain runaway health care cost inflation and its attendant adverse effects on people as well as government health programs. HMOs, as a proven competitive element in the system, have already contributed to restraining this inflation through cost savings to employers and creating a community awareness of cost effective health care delivery. HMOs, other new alternatives being tried, prospective Medicare reimbursement, new state systems for Medicaid, increased employer and labor roles in cost containment should all contribute to controlling health care costs. These and other activities in the private sector should be given a chance to prove out before such dramatic measures as tax caps are enacted.

Sincerely,

James F. Doherty
Executive Director

Enc.

Impact of Step-Rating and Price Sensitivity on Disenrollment and Risk Selection

The Experience of a Group Practice HMO

Karen Wintringham, M.H.A.

Introduction

Since July 1972, the Group Health Cooperative of Puget Sound (GHC) has provided prepaid health care coverage to enrolled employees of the state of Washington. In recent years, enrollment of state employees has constituted approximately eight percent of total GHC enrollment, representing the plan's largest employer group. It understandably concerned the Cooperative when more than 6,000 individuals disenrolled from the plan during the 1980 state employees' open enrollment period.

In an effort to ascertain the causes of the substantial enrollment loss, GHC undertook two separate research efforts. This paper reports the results of those two studies, exploring both the causes of the disenrollment and characterizing the risk selection experienced by the plan. The latter is then analyzed in relation to the change in the rating mechanism used in 1980. The paper concludes with implications of the apparent price sensitivity on health maintenance organizations (HMOs) operating in competitive markets.

Background

Group Health Cooperative of Puget Sound (GHC) employs community rating principles to establish monthly premiums for its approximately 285,000 enrollees. In the particular case of one of its largest employer groups, Washington State employees, GHC submits its community rate to the State Employees Insurance Board (SEIB). The SEIB designates a base carrier able to provide benefits to employees statewide, and pays that carrier's full premium for any state employee enrolling in the base carrier's program. Additional plans, including GHC, are also offered. Premium amounts in excess of the base carrier's are collected through payroll deductions; carriers charging premiums below the base carrier's plan derive no financial benefit for their cost effectiveness and receive revenues equal to their lower premium.

Both in 1979 and 1980, the premiums submitted by GHC to the SEIB exceeded those submitted by the base plan, Blue Cross. As a result, in 1979 any employee enrolling in GHC paid $1.60 per month through a payroll deduction. In 1980 a uniform deduction for state employees electing GHC coverage would have increased to $11.06. Instead, the uniform deduction was translated into the following four-step composite rates:

One adult	$ 3.00/month
Adult and spouse	$12.00
Adult and child/children	$ 9.00
Adult, spouse, and child/children	$20.00

As a result, an enrollee's 1980 payroll deduction increased a minimum of $1.40 from the 1979 rate and exceeded that for Blue Cross coverage by $3. The maximum increase (adult, spouse, and child/children) was $18.40, or $20 more than for Blue Cross coverage. (*Appendix A*)

Despite the obvious detrimental impact on GHC of the major disenrollment suffered in 1980, competing carriers claimed that the change in GHC's rate structure resulted in a favorable risk selection for GHC and, correspondingly, adverse selection for the other carriers. The extent to which this belief gained credence led GHC to study the selection question further.

In his impressive compendium of research on health maintenance organizations (HMOs), Luft includes reviews of research defining causes of consumer satisfaction and of risk selection.[1] Both of these topics relate directly to GHC's concerns with the 1980 disenrollment experience. To summarize Luft's already concise reviews, the literature supports the notion that visible cost differentials influence choice of health care coverage.[2] Once enrolled in an HMO, the individual generally is insulated from out-of-pocket cost considerations; determinants of satisfaction tend to shift to other factors. Here, too, Luft provides a thorough review of studies researching the determinants in a variety of settings.[3]

Of the multitude of studies characterizing reasons for satisfaction and risk selection, few focus on the impact of premium differentials. One study analyzes selection choices among four plan offerings over a period of three open enrollment periods.[4] Although the number of individuals remaining in a plan where premiums increased substantially were minimal ($n = 13$) and data were not displayed, the authors note measurably higher use rates for individuals electing to continue in the more costly plan than for those individuals who disenrolled.

More recent analysis by Sorensen and Wersinger investigates reasons for disenrollment from a prepaid group practice HMO in Rochester.[5] The HMO's premium increase resulted in a substantially higher rate than the local Blue Cross plan, and a major enrollment shift from the HMO to Blue Cross resulted. Of the disenrollees interviewed, only 11.2% cited high cost as the reason for termination. However, in a study reviewing choice by employees of Yale University, the sensitivity to price as a predictor of enrollment has been cited as a significant factor. Unfortunately, the impact of substantial benefit and coverage disparities between the two available choices were not controlled for, limiting the definition of the effect of price.[6]

In light of the research literature available, the direct comparison between Blue Cross coverage with no payroll deduction, and the noticeable rate increase particularly for larger GHC families, several hypotheses seemed plausible.

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The Group Health Journal

GHC set out to test whether the nature and the cause of the disenrollment experienced in 1980 could be described by the following:

1. Premium cost as a cause of disenrollment would increase significantly from 1979 to 1980;
2. Terminations would occur more frequently among non-single contracts; and
3. Individuals electing to remain at GHC would be likely to use GHC services more than those electing to leave would have.

This paper addresses each of these hypotheses using data generated from mailed questionnaires and from individual medical charts.

Methods

Survey of State Employees Disenrolling from GHC
Beginning July 1, 1980 GHC mailed questionnaires to every state employee who had been enrolled in GHC but elected to terminate that coverage during the 1980 open enrollment period. Information requested on the questionnaire focused on demographic characteristics, the extent to which GHC services had been used and at which locations, the level of satisfaction with GHC, the major reason for disenrolling, and the health plan to which people switched. GHC received 342 completed questionnaires (32% response rate) representing approximately 982 former enrollees. Responses were analyzed and compared to those collected during the 1979 open enrollment to ascertain changes in reasons for disenrollment.

Chart Audit of Active and Terminated Contracts
In order to test the question of whether GHC encountered favorable or adverse risk selection, individual medical charts were reviewed retrospectively and use rates analyzed. In addition to demographic and coverage information, counts were made of all outpatient visits, mental health visits, optometry visits, hospital stays, and hospital length-of-stays during the two-year period from July 1, 1978, through June 30, 1980.

Since most of the state employees electing GHC coverage use the GHC medical center located in the state capitol of Olympia, GHC focused its efforts on reviewing charts associated only with that clinic. Charts associated with a total of 400 contracts were analyzed, derived from 50 randomly drawn contracts in each of the four rate categories for both retained and disenrolled contracts. In the case of terminated contracts drawn in the stratified sample, all individuals on the contract whose coverage was inactivated were included in the study. Similarly, the study encompassed all individuals on any contract drawn in the sample of individuals remaining with GHC. A total of 808 individuals comprised the 400 contracts reviewed. Data analyzed were weighted to adjust for the disproportionate stratified sample. T tests were conducted to determine significance of the relationships under study and, where significant, are reported.

Further analysis of responses suggested consolidation into the five categories of normal attrition (death, moving from the service area), and dissatisfaction with cost, with benefits, with access, and with quality of care. *Appendix B* defines the components of each category and *Table 2* displays the percentage attributable to each category. Among the primary reasons for leaving in 1980, cost exceeds all others (40%), with only 7% resulting from normal attrition due to factors beyond the control of GHC. By contrast, in 1979 normal attrition contributed 24% while cost considerations prompted only 4% of the responses. For both years, dissatisfaction with access was the leading secondary cause identified (48% in 1979 and 45% in 1980). Even as a secondary reason, dissatisfaction with cost increased from 1% to 17% by 1980.

One final question asked respondents to characterize their general level of satisfaction with GHC. *Table 3* documents an increased level of satisfaction from 66.6% in 1979 to 73.1% in 1980. Of the unsatisfied respondents, those who were very dissatisfied decreased from 8.3% to 7.5%. Combined with the reasons for disenrollment, one could characterize a major portion of individuals as satisfied with the Cooperative but unwilling to pay the assessed payroll deduction. Faced with an economic choice, 95.2% of the disenrollees switched to the base plan, Blue Cross, where no payroll deduction was required.

Table 1 Major Reason for Leaving GHC

	Category	**1980**	**1979**
a.	I am moving away from the Puget Sound area	2.9% (10)	8.3% (11)
b.	My GHC membership is now covered through my spouse's or other family member's plan	3.2% (11)	15.2% (20)
c.	GHC did not provide all the services I want my health plan to cover	5.3% (18)	14.4% (19)
d.	I thought the waiting time for scheduling appointments was too long	4.1% (14)	4.5% (6)
e.	GHC facilities were located too far from my home and/or office	7.9% (27)	12.9% (17)
f.	The payroll deduction for GHC coverage was not acceptable to me	40.1% (137)	3.8% (5)
g.	I felt that the care I or my family received at GHC was impersonal	6.1% (21)	8.3% (11)
h.	I was not satisfied with the quality of care I or my family received at GHC	19.0% (65)	22.7% (30)
i.	While I travel away from the Puget Sound area, I would prefer more comprehensive coverage than GHC provides	3.2% (11)	2.3% (3)
	Other	8.2% (28)	7.5% (10)
		100.0% (342)	100.0% (132)

Table 2. Aggregated Reasons for Leaving GHC

Category*	Primary Reason 1980	Primary Reason 1979	Secondary Reason** 1980	Secondary Reason** 1979
Normal attrition	7%	24%		
Dissatisfaction with cost	40%	4%	10%	8%
Dissatisfaction with benefits	8%	17%	17%	1%
Dissatisfaction with access	13%	17%	12%	11%
Dissatisfaction with quality	27%	31%	45%	49%
Other	8%	8%	17%	31%
	103% (342)	101% (132)	101% (186)	100% (75)

* See Appendix B for listing of responses by category.

** Individuals may submit multiple responses for this question. All are included here.

Results

Survey of State Employees Disenrolling from GHC

The survey instrument used both in 1979 and 1980 afforded two opportunities to cite reasons for leaving GHC. The first asked for the one major reason, while the second allowed individuals to list any additional reasons contributing to their decision. *Table 1* lists the responses to the first, the one major reason, in the order the categories appeared on the questionnaire. The most striking change in responses from 1979 to 1980 was the identification of the payroll deduction as the major reason for disenrolling; the percentage of respondents citing this reason increased dramatically from 3.8% to 40.1%. Given an average covered family size among 1980 respondents of 2.9, the average payroll deduction had increased from $1.60 to either $9.00 or $20.00 per month.

A second response of note is the number of individuals citing dissatisfaction with quality of service. In 1979 the category contributed the largest percent of respondents with 22.7%. This decreased to 19.0% in 1980, falling behind cost as a major reason for disenrolling. It should be noted that the respondents' interpretation of "quality of care" may not be limited to the skill of practitioners but may include such factors as whether they obtained appointments as promptly as desired or whether they were treated by a Medex instead of a physician.

Chart Audit of Terminating and Active Contracts

Once having determined that the reasons for terminating coverage with GHC had changed dramatically from 1979 to 1980 and that the primary agent of change was cost, it became particularly intriguing to determine differences in use of health services by individuals disenrolling and by those continuing coverage with GHC. It seemed most reasonable that individuals staying at GHC would consider this actual or potential use of services adequate enough to justify payment of an increased payroll deduction. One might hypothecate that those who disenrolled used services infrequently and perceived their future use to remain too low to justify the increased expenditure. GHC assumed further that as the payroll deduction increased within the four-step rate categories the tendency for healthier individuals to disenroll would prove even more dramatic. Examination of the distribution of contracts comprising the total populations of disenrolled and retained individuals reveals a clear difference among rate categories (*Table 4*). A significantly lower proportion of contracts with only an adult were terminated than were retained (24.3% versus 30.8% respectively). Little difference exists between the second and third rate categories. The fourth category of adult, spouse, and child/children accounted for 43.1% of terminated contracts but only 33.2% of retained contracts.

Table 5 arrays the number of sampled individuals studied in each of the four rate categories by category of disenrolled or retained with GHC at the close of the 1980 open enrollment effort. It is of interest that the average number of individuals studied in the categories with discretionary size (Adult and Child/Children and Adult, Spouse, and Child/Children) are smaller among disenrollees. *Table 6* further clarifies this relationship; the average contract size at the time individuals chose to disenroll or to remain with GHC differs markedly only for the two rate categories with children (1.6 vs. 2.6 for Adult & Child/Children and 2.7 vs. 3.8 for Adult, Spouse, Child/Children). The weighted average contract size for the disenrolled sample was 1.79 persons compared to 2.59 for those retained.

Table 3. Level of Satisfaction with GHC

Category	Respondents 1980	Respondents 1979	Percentage 1980	Percentage 1979
Very satisfied	94	30	29.5%	24.2%
Generally satisfied	149	56	46.7%	45.2%
Generally unsatisfied	52	24	16.3%	19.4%
Very unsatisfied	24	11	7.5%	8.9%
	319	124	100.0%	97.7%

Table 4. Population Distribution

Rate Category	Disenrolled Percentage	(N)	Retained Percentage	(N)
Adult	24.3%	(297)	30.8%	(1,562)
Adult and Spouse	13.4%	(164)	14.1%	(714)
Adult and Child/Children	19.1%	(233)	22.0%	(1,116)
Adult, Spouse, and Child/Children	43.1%	(526)	33.2%	(1,687)
Total Contracts		(1,220)		(5,079)

Table 5. Enrollees Studied by Rate Category

	Disenrolled Percentage	(n)	Retained Percentage	(n)	Totals Percentage	(n)
Adult	14.2%	(50)	11.0%	(50)	12.4%	(100)
Adult and Spouse	24.7%	(87)	18.4%	(84)	21.2%	(171)
Adult and Child/Children	23.3%	(82)	28.9%	(132)	26.5%	(214)
Adult, Spouse, and Child/Children	37.8%	(133)	41.7%	(190)	40.0%	(323)
	100.0%	(352)	100.0%	(456)	100.1%	(808)

Analysis of the use of specific services during the two year period studied documented a dramatically higher use rate among individuals electing to remain with GHC. Use of mental health and optometry services were too negligible among both samples to warrant further testing. However, the volume of both outpatient and inpatient services supported comparisons between the two samples. *Table 7* documents the significantly higher annualized number of outpatient visits per enrollee of those individuals remaining with GHC (weighted visits of 3.98 compared to 2.41 per person per year). The annualized hospital days per thousand show an even greater disparity; enrollees electing to remain with GHC used 388 days compared to 83 among individuals disenrolling (*Table 8*). For both outpatient visits and inpatient days the pattern of significantly higher use by retained individuals holds true for each rate category and for each age category.

Beyond the major decision of whether to disenroll or continue coverage with GHC, each contract holder in all but the single adult category could consider the option of altering coverage arrangements for his or her family. Presumably such decisions would be affected by the price sensitivity generated by the rate structure. Several options might have been available, primarily involving transferring children to the spouse's health plan. However, it also appears to be the case that a sizeable number of state employees are married to state employees. Particularly in contract years where the State's health plan fully covers the GHC premium, some of these individuals enroll each other as dependents on their contracts. In 1980 double coverage would have increased each spouse's payroll doduction from $3.00 to $12.00 monthly; the deduction increase would be even greater if children were similarly double covered.

Among the disenrollees studied, 36.0% were involved in contract reduction or shifting (*Table 9*). In some cases unnecessary double coverage was eliminated, thus reducing the monthly payroll deductions. In other cases shifts resulted in two seperate contracts instead of one larger contract, again reducing the deduction. Nineteen contracts dropped the contract holder; the remaining enrollees were transferred to the other parent's contract. One curious anomaly did occur; twenty-seven contracts reduced contract size by a total of thirty-four individuals but achieved no rate reduction.

Discussion

The data presented document a dramatic difference between state employees electing to disenroll from GHC and those choosing to remain with the plan. The choice made was most strongly influenced by cost considerations in a year when premiums both increased and changed from a uniform rate to a four-step rate.

Three hypotheses were proposed and tested. First, terminations did occur more frequently among rate categories with more than one individual per contract. Second, the premium cost was identified as the predominant reason for terminating

Table 6. Average Contract Size at Time of Decision

Rate Category		Disenrolled	Retained
Adult		1.00	1.00
Adult and Spouse		1.74	1.68
Adult and Child/Children		1.64	2.64
Adult, Spouse, and Child/Children		2.66	3.80
	Weighted:	1.79	2.59

Table 7. Outpatient Visits Per Year

	Disenrolled	**Retained**
Total*	2.41	3.98
By Type of Contract		
Adult	2.52	3.75
Adult and Spouse	2.26	4.59
Adult and Child/Children	2.20	4.16
Adult, Spouse, and Child/Children	2.54	3.80
By Age		
0 - 17 years	2.47	3.86
18 - 35	2.30	3.79
36 +	2.45	4.56

*$p < .05$

coverage. Third, and most importantly, GHC encountered severe adverse selection as result of the disenrollment process. The adverse selection occurred in all rate categories and across all age categories.

The results presented support the logical assumptions that health care coverage is price sensitive and that the sensitivity is affected by consumers' perception that they will use the services often enough to justify the monthly premium. Not surprisingly, the individuals electing to pay increased premiums already had a documented use of services significantly higher than those individuals who chose to disenroll. The analysis described also provides some estimate of the disenrollment that might result from four different levels of health premiums. GHC faced the prospect of announcing an $11 per contract payroll deduction compared to no deduction for Blue Cross coverage and an increase of $9.40 over the previous year's GHC coverage. The conversion to a four-step composite rate clearly reduced the financial burden on smaller contracts and, correspondingly, reduced the loss of contracts in the individual adult rate class. A large number of individuals disenrolled from large contracts; others shifted coverage in ways that retained coverage but reduced out-of-pocket costs.

The outcome of adverse selection in the face of economic choice bodes poorly for health maintenance organizations. At a time when procompetitive legislative initiatives support the notion of rebates to consumers choosing less costly health plans, the potential for adverse selection appears severe. The experience of GHC documents the willingness of healthy individuals to choose less costly health plans. Conversely, individuals who know or believe they will use services are willing to pay the additional cost.

One additional outcome should be noted: in 1981, the premiums for State employees' coverage with GHC was paid in full by the employer. Few of the 1980 disenrollees returned, but equally few covered individuals left GHC coverage. Individuals appeared less willing to switch coverage when no economic advantage was apparent.

Analysis completed by the GHC Marketing Department has shown further that a majority of the individuals returning in 1981 had left in 1980 because of the payroll deduction; the majority returning did so in response to dissatisfaction with copayments of the alternate plans.[7] Further analysis and documentation of the price sensitivity to both premiums and out-of-pocket costs of plan selection, the corresponding potential for adverse selection, and the degree of willingness of individuals to alternate plans year to year will be required if legislative initiatives equitable to health maintenance organizations are to be achieved.

Acknowledgement

The author wishes to express her personal thanks for substantial support and assistance from Barbara Norton and her staff at the GHC Olympia Medical Center, from Barbara Calvert of the GHC Marketing Department, and from Lillie

Table 8. Hospital Days Per 1000 Per Year

	Disenrolled	**Retained**
Total*	83	388
By Type of Contract		
Adult	100	510
Adult and Spouse	180	480
Adult and Child/Children	30	440
Adult, Spouse, and Child/Children	70	200
By Age		
0 - 17 years	63	361
18 - 35	42	238
36 +	165	454

*$p < .10$

Table 9. Extent of Rate Category Shifting

Description of Rate Category Shift*	Contracts	Individuals Terminated	Monthly Savings Per Contract**
Category 4 —> Category 3	6	7	$11
Category 4 —> Category 2	6	10	$ 8
Category 4 —> Category 1	3	8	$17
Category 3 —> Category 2	0	0	($ 3)
Category 3 —> Category 1	11	15	$ 6
Category 2 —> Category 1	11	11	$ 6

* *Category 1 = Single Adult, Category 2 = Adult and Spouse, Category 3 = Adult and Child/Children, Category 4 = Adult, Spouse, and Child/Children.*

** *Assumes shift to non-state employee contract. However, if Mr. and Mrs. Smith are both state employees, savings can still be achieved but not as large as those cited. For example a shift from Category 4 (Mr. Smith, Mrs. Smith, and daughter) to Category 3 means a shift to Category 3 (Mr. Smith and daughter) plus Category 1 (Mrs. Smith). This would save $8 instead of the $11 noted in the table.*

Peterson of the GHC Research Department. In addition, special credit is due Dr. Thomas W. Bice, Professor and Director, Program in Health Administration of the University of Washington for his statistical counseling on the validity of the data and interpretations presented.

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Appendix A

Comparison of Monthly Payroll Deductions

	1979		1980	
	Blue Cross	GHC	Blue Cross	GHC
One Adult	$0	$1.60	$0	$3
Adult and Spouse	$0	$1.60	$0	$12
Adult and Child/Children	$0	$1.60	$0	$9
Adult, Spouse, and Child/Children	$0	$1.60	$0	$20

Appendix B

Categories for Responses to Reasons for Leaving Group Health Cooperative

Normal Attrition
- Moving away from the service area
- Health coverage through spouse or other family member
- Preference for non-GHC physician

Dissatisfaction with Cost
- Payroll deduction

Dissatisfaction with Access
- Waiting time for scheduling appointments is too long
- GHC facilities located too far away
- Sometimes treated by medex or nurse instead of physician
- Prefer to self-refer to specialists
- Change of personnel
- Lack of a specialty center and hospital in Olympia
- Lack of optical department at clinic

Dissatisfaction with Quality
- Impersonal care
- Quality unacceptable
- Unprofessional staff
- Pharmacy services poor

Dissatisfaction with Benefits
- GHC doesn't provide all services desired by terminator
- Lack of comprehensive out-of-area coverage
- In-area emergency coverage not sufficient

STATEMENT ON:

THE ADMINISTRATION'S PROPOSAL TO CAP THE AMOUNT OF EMPLOYER-PROVIDED MEDICAL CARE THAT MAY BE EXCLUDED FROM AN EMPLOYEE'S INCOME

BY

DOUGLAS A. FRASER, CHAIRMAN,
HEALTH SECURITY ACTION COUNCIL

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON FINANCE

JUNE 22, 1983

WASHINGTON, D. C.

The testimony I present to you is in behalf of the Health Security Action Council. We are an organization of 100 distinguished Americans who work with a coalition of labor, business, professional, senior citizen, farm, civil rights and youth organizations.

The national health care scene is replete with special interest groups -- hospitals, doctors, nursing home operators, commercial profit-makers, and the like. We too represent special interests. We seek through education and imagination to protect the interests of consumers and patients.

Because we have studied and worked closely with health care programs over the years, we believe we have perspective on and experience with the more recent developments. None is new. The course and causes of the runaway increases in health care costs were understood and first pointed out by our committee in 1969, and innumerable times since then. What is new today is that many decision makers in the public and private sector have only recently become aware of the health care trends of the last decade and a half. With the zeal of recent converts they have rushed to find "quick fixes" to the deep-rooted and multiple causes, and in their hurry they have bought "snake oil" palliatives rather than meaningful solutions.

So-called tax caps on employer paid health insurance premiums are one of these "snake oil" solutions that will not work. We urge this committee to reject this proposal, as it did last year.

We are convinced that comprehensive health care of good quality is essential to the continued improvement of the health of each of our citizens. Every industrial and semi-industrial nation in the world, with but one exception, recognizes this and through public programs provides such protection. In the United States, not only is this not true, but in the last two and a half years we have witnessed a regular retreat from such health protection.

In the rest of the western world, an unemployed worker and family are given continuing health protection as long as they are without work. In the United States in 1983, we are witnessing the sad political scrambling while the Congress debates how little health insurance protection at how small a cost can we provide to workers who have lost their jobs and cannot find new ones.

The citizen consumer is bewildered by the doctor who, as assistant secretary of the Department of Health and Human Services, is promoting the administration's health insurance tax cap proposals because they presumably will increase employee deductibles and co-insurance. They will thus, according to this thinking, save money for the government and for insurance companies by raising still more the economic barriers to prevention, early detection and treatment of illness and impairment.

We find it difficult, if not impossible, to reconcile this with the advice the medical profession has been giving us for years -- namely, that it is good medicine and good medical economics to structure health insurance programs which encourage prevention, early detection, treatment and rehabilitation programs.

And who in the administration is listening when the health insurance industry is telling them and the Congress of their opposition to tax caps because they are the wrong way to save money, and it is in fact doubtful that promised savings will be achieved?

This philosophy of providing less protection at more cost to the individual pervades most of the measures which we see coming from the Congress and the White House. Unfortunately, proposals which would make workers pay increased taxes on part of the premiums paid by employers is a further reflection of this negativist philosophy.

The Health Security Action Council urges this committee to join us in opposing a tax cap because it is a bad idea. In the 97th Congress, such a proposal was rejected. Currently, it is opposed by most of the principal actors affected -- business, labor, the insurance industry. It is supported only by a narrow band of misguided health providers.

We have in our coalition a number of representatives of unions, farmers and other workers. The proposed tax cap would turn back the clock on years of hard fought improvements in health insurance gained through collective bargaining. These gains were paid for by the workers who gave up proposed wage improvements and other benefits such as pensions, life insurance, and supplementary unemployment benefits because they placed a higher priority on health protection for themselves and their families.

In my recent experience as President of the United Auto Workers Union, I have had trying experiences in working with our members to negotiate concessions we would make to major employers in order to save members' jobs, and even entire corporations. We made billions of dollars of such concessions. But it should be instructive to the members of this committee that, in the decision-making process, our members made no concessions in the health care benefits they had negotiated over the years for themselves and their families.

The advocates of this tax cap plan propose to interfere in the collective bargaining process, to take away from union members a portion of that for which they paid in collective bargaining and to substitute their views for those of union members as to what's good for them and their families.

The Congressional Budget Office estimates that a cap set at $1800 annually for family coverage and indexed for inflation thereafter would result in employer-based health insurance benefits of 13% less by 1987 than if current policies were continued.

Advocates of the tax caps repeatedly affirm they would influence workers to buy low option plans whose premiums are lower and thus reduce health care costs.

This, however, is not correct. When given the choice, even though it means additional payments for them, federal employees prefer a comprehensive plan. And experts in health care have pointed out that if knowledgeable consumers were to follow the economics in tax caps, the less healthy beneficiaries would choose the high option comprehensive plans, thus assuring higher costs, as those who are sicker and disabled engage in understandably adverse selection.

In recent years, the Congress and many of our social institutions have struggled with measures which would remove discrimination against the elderly, ethnic minorities and women, so that they may fully and equally enter the mainstream of our society. Proponents of health insurance premium tax caps, perhaps unwittingly, would build new walls with which future generations would have to struggle. It is well-known that most insurance premiums are experience-rated. Older people use more health services. Their higher premiums make it more difficult for them to secure and hold on to jobs. This proposal would make things worse. They would be required to pay added taxes because they are older and because they are not as healthy as others. Women, too, have higher health insurance premiums because they require more health services.

Similarly, workers in mines, foundries, steel mills, and auto and battery plants are subject to major occupational hazards to their health and safety. Because their ability to work is in a major way dependent on that safety and because numbers of employers have been unable or unwilling to provide a wholly hazard-free environment, through collective bargaining, these workers have allocated funds to buy high quality comprehensive health benefits. Now the advocates of tax caps would require that this protection, already paid for at bargaining tables, be given up at least in part.

The Health Security Action Council recognizes that this country faces a severe problem in a health care system beset by unconscionable increases in costs. The quality of the care often is uncertain, and tens of millions of our fellow Americans are without any needed protection.

As a start in the right direction, an expert group of our Council has helped to develop a constructive health care cost containment plan sponsored by Senator Edward Kennedy in Senate Bill 814. We commend this to your attention as a constructive alternative to the incomplete and unsound tax cap proposals.

TESTIMONY

OF

ALBERT A. FORMICOLA
President and Chief Executive Officer
Hotel Association of New York City, Inc.

ON BEHALF OF THE

TRUSTEES OF THE INSURANCE, SPECIAL INSURANCE, UNION FAMILY MEDICAL AND DENTAL FUNDS OF THE NEW YORK HOTEL AND MOTEL TRADES COUNCIL AFL-CIO AND THE HOTEL ASSOCIATION OF NEW YORK CITY

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON FINANCE

June 22, 1983

Mr. Chairman, Members of the Committee

My name is Albert Formicola and I am testifying jointly on behalf of the Trustees of the Insurance, Special Insurance, Union Family Medical and Dental Funds of the New York Hotel and Motel Trades Council, AFL-CIO and the Hotel Association of New York City. Together we are entrusted with the medical insurance funds and the well-being of approximately 95,000 employees, retirees and their dependents in New York City. As representatives of labor and management, we believe that if the legislation before you is enacted it will seriously and adversely affect not only the pocketbooks of our employees but the very quality of life.

Gentlemen, we believe this proposal to tax employer paid medical premiums over a certain amount would discriminate against women, the elderly and the low income employee; it is misdirected and views the problem of health costs and care with tunnel vision.

The reasons given by the proponents of this change are either "medical cost containment" or "revenue raising." Treasury calls this "returning fringe benefits to the mainstream of taxable income." We believe both of these premises are false and this proposal will neither raise revenue fairly nor contain health costs.

DISCRIMINATORY

The proposal discriminates against women and the elderly because historically these groups require greater medical coverage. Group plans covering industries or employers in which the workforce is predominately female or have a substantial number of older workers - industries like ours - will be particularly disadvantaged.

But as obvious as it is that these groups will suffer more than others, the profound detrimental effect this proposal will have on the lower paid employee is even worse.

This proposal will not only take a bigger tax bite out of the lower paid employee, it will take two bites! He or she will have to pay additional income tax and additional social security taxes.

For example. Take a working couple earning only $20,000 a year. If the employer contributed $200 a month to each of the couple's health plans this proposal would increase their income and social security taxes by $353! That's nearly 2% of their gross pay. If the same couple earned $100,000 they would not pay any additional social security taxes and their tax increase would be less than 1/2 of 1% of their gross pay.

This example is not based on the "worst case" imaginable. In fact, I believe the Congressional Budget Office analysis of this proposal assumes that the excess of the contribution that will be subject to tax will be taxed at an average marginal rate of 38%!

MISDIRECTED

The proposal is misdirected whether the purpose is cost containment or increasing revenues.

IF YOU WANT TO CONTAIN HOSPITAL AND MEDICAL COSTS THEN WE RESPECTFULLY SUBMIT THAT YOU DIRECT YOUR ATTENTION TO THE HOSPITALS AND THE PROVIDERS OF MEDICAL CARE.

Don't try and slow the dog by pulling on its tail. Don't try and slow the rise in medical costs by denying access to adequate medical care to the very groups who need it the most. And make no mistake-you will be denying access to adequate medical care to the groups that need it most - the chronically ill and elderly. You will be denying access to medical care to those groups who cannot afford even the current cost of medical care and who cannot afford to pay an additional tax to be adequately covered.

The young and healthy worker may not need or use extensive medical treatment although catastrophe can strike at any age. However the older worker - naturally and by necessity - will historically require greater and more frequent treatment and it is this group and those of all ages felled by catastrophe who will be hurt most by this proposal.

As a revenue raising device this proposal is also misdirected and inefficient. It flies in the face of the progressive nature of our income tax and contradicts our social goals by placing the tax burden on those who are most ill and need medical service the most.

There also seems to be something inherently contradictory in an Administration pledged to an income tax decrease for everyone regardless of ability to pay and at the same time proposing a tax increase that falls most heavily on those least able to pay. A classic example of the right hand giveth and the left hand taketh away.

TUNNEL VISION

This proposal views rising health costs through a tunnel and promises a simplistic solution. If the cost of medical services is too high - simply have less people use those services. There is apparently no thought given to what groups will be denied medical care or their ability to pay for it. You can save the cost of a bandaid by not covering a wound. But what will be the savings when the wound becomes infected? How much will it cost to repair at that point? In the final analysis, will your medical costs have gone up or down?

The proposal is short sighted and narrow in view because it takes into account only its assumptions of immediate cost savings. But are those assumptions correct?

- If medical insurance is restricted to hospital coverage will the doctor's charges go down or will he hospitalize the patient in order to come under the insurance umbrella?
- If an employee drops preventive medical coverage because he or she can't afford it, will they then incur huge hospital surgical fees that could have been prevented at the cost of a bandaid? Is this cost containment?

- The proposal would increase an average taxpayer's tax by $189. Although this is not by any means insignificant, it does not tell the whole story in that the out-of-pocket expense for uninsured services will be far, far greater.

A final note. We do not feel comfortable with having medical insurance premiums lumped into the term "fringe benefits." Medical coverage is not in the same category as airline discounts or free parking offered to employees. Medical care is not voluntary. It is not a fringe benefit - but a basic benefit - because without our health we have no life.

Thank you for your time and attention.

RUSH!

Executive Memorandum
The Heritage Foundation
513 C Street N.E. Washington, D.C. 20002 (202) 546-4400

6/9/83 Number 25

A TAX CAP: BAD ECONOMICS, BAD POLITICS

Thwarted in his attempt to eliminate completely the third year of the tax cut, House Speaker Tip O'Neill now is attempting to gain support for an effort to cap the benefits of the July 1 income tax cut at $700. Given the Speaker's record of voting for practically every spending measure within reach, his conversion to balanced budgets is a little surprising. A more likely explanation for the proposal is that the House leadership simply wants to bring in more tax revenue so that it can unleash more federal spending.

Many Congressmen sincerely believe, of course, that the deficit and interest rates can be lowered painlessly by tapping the rich for a few more tax dollars. Yet even if increased tax revenues were the answer to budget deficits--which they are not--the tax cap is perhaps the worst option Congress could choose. The cap would wreak havoc on capital investment, seriously deplete the savings pool, and drive affluent Americans from the taxable financial markets and into non-taxable consumption expenditures and tax shelters.

The tax cap is supposed to bring in more tax revenues, and so reduce the crowding out effect of government deficits. But higher tax rates on more affluent Americans would also discourage savings and distort incentives, slowing the flow of funds into the capital markets by at least as much as the current projected deficits will suck from it. It makes no difference to interest rates or the capital markets whether crowding out occurs because of deficits or less private saving.

The tax cap proposal is so destructive to capital formation because it is the upper-income groups who do most of the saving and investing in the U.S. Americans who make over $50,000 a year typically save over 35 percent of their income; those in the $10,000 to $16,000 bracket save only 2.8 percent. Upper-income Americans also are the main creators of new small businesses and are heavy investors in the stock and bond markets. The tax cap would sharply reduce small business investment, since about three-fourths of all businesses pay tax according to the personal income tax schedule, rather than corporate rates.

The tax cap would also induce many affluent Americans to shift their money into tax exempt bonds, tax shelters, non-taxable consumption. According to Treasury figures, the cap would cause marginal tax rates at the $35,200 taxable income level to jump from 28 percent to nearly 37 percent. Taxpayers around this breaking point would think twice about working longer hours or making investments that would shift them into a much higher tax bracket.

If congressional leaders really wanted to soak the rich, they would not only protect the July tax cut, but actually cut taxes further for

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

upper-income Americans. When the top marginal tax rate was cut by 23 percent, in 1964, the number of tax returns reporting an adjusted gross income of $50,000 or above skyrocketed. In the five years preceding the 1964 tax cut, the number of such returns ranged between 125,000 and 162,000, according to a study by economists James Gwartney and Richard Stroup. But after the top marginal rate reduction, the number of these high income returns surged to 272,000 by 1966. Tax revenues from this income group also grew sharply. In the three years prior to the tax cut, tax revenues from returns of taxpayers earning $50,000 or more grew at an annual rate of 6.1 percent. But in the three years after the tax cut, taxes from the same group grew at a 14.1 percent annual rate.

The same pattern can also be detected with the Reagan tax cut. As the Wall Street Journal has reported, the Treasury had been expecting revenue loss of about $2 billion in 1982 from taxpayers in the top bracket, thanks to the 1981 tax changes. Instead, estimates suggest that the revenue in fact grew by about $8 billion. Higher tax rates only cause the rich to flee into tax avoidance schemes, leaving the middle- and lower-incomes to suffer the consequences.

The tax cap scheme is hardly attractive from a political standpoint. Notwithstanding the anti-rich rhetoric of its supporters, the tax cap would mainly hit middle-income Americans. The $700 cap would begin to take effect at $35,200 of taxable income for joint returns. The many Americans in that income group facing a monthly mortgage payment and college expenses would hardly consider themselves rich.

Those now so assiduously fanning the flames of envy against the rich ignore the fact that Americans with adjusted gross incomes above $50,000 a year pay 34 percent of all personal income taxes even though they constitute only 5 percent of all taxpayers. According to figures provided by W. R. Grace and Company, if the government absconded with every penny of taxable income in the income brackets above $50,000 a year, the Treasury would have raised only $76.4 billion in 1980, barely enough to cover one-third of this year's budget deficit.

Upper-income taxpayers, like all other taxpaying groups, deserve the full July tax cut because they have experienced sharp tax increases due to bracket creep. A taxpayer earning $50,000 of gross income in 1983, who had only just kept pace with inflation during the previous decade, would have experienced a cumulative tax increase of around $7,500, solely due to bracket creep, says W. R. Grace. The third stage of the tax cut will offset less than 10 percent of that hidden tax hike. If the July tax cut is capped, the full burden will remain.

In the end, efforts to "soak the rich" hurt everyone, by discouraging investment, saving, and entrepreneurship. Congress should quickly reject the faulty logic of the tax cap scheme, and honor the promise it gave in the 1981 tax act to cut taxes across-the-board. Tinkering with the cut at this stage would be both a breach of faith and a body blow to the recovery.

Thomas M. Humbert
Walker Fellow in Economics

For further information see:

Thomas M. Humbert, "Seven Reasons for Saving the Tax Cut," Heritage Foundation Backgrounder #260, April 12, 1983.

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"Voodoo Economics," editorial, The Wall Street Journal, June 7, 1983.

June 22, 1983
Washington, D.C.

Statement of

Howard Young, Special Consultant to the President and Director, Social Security Department, UAW

on the subject of

Taxation of Fringe Benefits

before the

Committee on Finance
United States Senate

In behalf of:

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW

Introduction

The United Auto Workers Union appreciates the opportunity to present our views to this Committee on the very important issues before it. This statement contains the views of the UAW on the federal income tax treatment of certain specific types of fringe benefits.

We would first like to emphasize our view that the tax treatment of fringe benefits should stem from an evaluation of the merits of the particular fringe benefit involved (including its actual or expected utility to various income and demographic groups). The UAW has not automatically supported all efforts to expand favored tax treatment of employee benefits; and we have not automatically opposed all changes that would restrict favored tax treatment. For example, we did not oppose the fringe benefit changes in TEFRA.

However, we believe the tax treatment of fringe benefits should not be viewed as a source of revenues to reduce federal budget deficits. We do not suggest that the budget impact of such tax treatment is irrelevant; it is a valid consideration in determining whether the fringe benefit is worth the tax expenditure involved. We also believe Congress is justified in imposing conditions - such as the anti-discrimination rules for pension plans - when fringe benefits are subsidized by large tax expenditures. Nevertheless, these concepts are different from the idea that the tax treatment of fringe benefits should be determined by a desire to change the size or balance of the federal budget.

In the current situation, the members of this Committee probably are aware of the UAW's support for efforts to increase federal revenues in FY 1984 and subsequent years. We support proposals to cap the 1983 tax cut at $720, and to repeal indexation; we have opposed repeal or delay of withholding on interest and dividends; as will be mentioned later, we believe deductions for individual retirement accounts (IRAs) are inappropriate, just as was the treatment of interest from the so-called All Savers certificates. In these, and many other areas, tax loopholes should be closed and tax expenditures reduced in ways that bring greater fairness to the overall tax code.

We believe these actions would be far preferable to taxing fringe benefits. When viewed in isolation, the exemption of certain fringe benefits from taxation may appear to have questionable income effects, but in reality it provides desirable social results and is equitable when viewed in the context of the total tax system.

We also maintain that it is the Congress of the United States, the elected representatives of the people, who should make the judgments concerning which fringe benefits should and should not receive favored tax treatment. Such decisions reflect social policy considerations which should not be delegated to the Internal Revenue Service. Therefore, we urge that the moratorium on IRS rulemaking with regard to fringe benefits be extended until the Congress can act on the specific issues.

Tax Cap on Health Care Benefits

The UAW long has been on record calling for reform of the American health care system in order to control inflation and improve delivery of services to people. We have expressed our concern about the millions in our society, including families of the unemployed, who are denied access to decent health services because they have no insurance coverage and are unable to pay. We have protested the inefficiency, disorganization and wastefulnesses of the health care delivery system. We have stated our alarm as health care expenditures have continued to consume an ever larger portion of our nation's scarce economic resources.

National health expenditures now consume 10.4 percent of Gross National Product, a number projected by the government to grow to 12 percent by 1990 if nothing is done. The impact of such rising costs on our negotiated health benefit programs has been acute; it has complicated the collective bargaining process, and has contributed to rising labor costs in a manner not experienced by other countries with better organized medical care systems.

Rather than address the root causes of skyrocketing health care costs, the Reagan Administration and a few in the Congress have proposed to begin to tax workers for health insurance premiums paid by their employers.

This tax is proposed as a way of restraining runaway inflation in the costs of health services. It will not work. It would actually increase the ills of an already sick health care system.

Under the proposal, tax free employer contributions towards employee health insurance premiums would be capped at $70 per month for individuals and $175 per month for families. Workers would be required to pay income taxes on employer premium payments in excess of such a cap. Many would end up paying federal income taxes in 1984 on more than one-third of the health insurance premiums paid by their employer. The tax cap might cost a single worker about $125 to $150 per year in increased taxes, and as much as $300 to $375 yearly for a worker with a family.

The tax cap reflects the mistaken notion that health care costs are so high because workers have too much health insurance coverage. Supposedly, if we had less, the problems would go away. Accordingly, the tax cap is aimed at emasculating the kind of broad, comprehensive service benefits the labor movement has struggled to achieve for its members for more than 30 years.

Even with all the progress the UAW and other major unions have made in increasing the health care protection for our members and their families, it is erroneous to suggest that workers have too much insurance. Our estimates are that UAW members employed by the major auto companies pay on the average about 30% of their basic medical care costs out-of-pocket, primarily because of the absence of routine doctors' office coverage. Many pay more. This is in addition to extensive patient copayments required in our dental, prescription drug, mental health and vision care programs. How much more should the victims of medical care inflation be required to pay? Our members, and most other workers, need more insurance protection, not less.

We see the tax cap as a threat to UAW members and to all workers:

- It would impose unfair new taxes on families wishing to maintain comprehensive protection against medical costs.
- It would create pressure to reduce negotiated health care benefits, to add copays and deductibles, and to drop various coverages (such as dental and vision care) from employee health benefit plans.
- It would penalize groups with more older workers who need to use more health care services. This in turn would discourage employment of older workers.
- It would penalize workers in higher risk occupations, such as assembly line workers, steel and foundry workers and mineworkers.
- It would unfairly affect certain geographic regions because of variations in medical care costs in different areas.
- It would put pressure on employers and unions to reduce coverage for preventive health services. Such barriers to prevention and early treatment of illness could lead to increased use of high cost hospital inpatient facilities.
- Several measures enacted under the Reagan Administration have shifted costs from the federal Medicare program to negotiated employee benefits programs. It is unconscionable that the government would actually turn around and tax employees for such costs forced upon their benefit programs by government action.

The tax cap proposal is based upon mistaken notions about health care economics, about physician and patient behavior, and about the true causes of rising health care costs. Proponents of reducing insurance and increasing patient cost sharing fail to realize that:

1. There is no study which indicates that cost sharing has any long term effectiveness in reducing total health care costs. One only has to look to the federal Medicare program to see the ineffectiveness of cost sharing in controlling costs. Medicare has had extensive deductibles and coinsurance since its beginning in 1966, and both have increased over the years. Yet the cost of the program to the federal government has risen from $4.5 billion in 1967 to nearly $60 billion in 1984.

2. The effect of cost sharing on health status is uncertain. In fact, there is some evidence that patient cost sharing can serve as a barrier to early treatment and actually increase costs because more expensive treatment is required for conditions which have deteriorated due to postponement of care.

3. After the patient makes the decision to go to the doctor in the first place, virtually all decisions about what services are to be provided are made by doctors and other providers. Deductibles and copayments have been shown to have little effect on treatment decisions made by doctors.

- Consumers do not admit themselves to the hospital or arrange for their discharges.
- The consumer does not make the decision to stay in the hospital for an inordinate amount of time.
- Consumers do not write prescriptions for themselves.
- Consumers do not order an array of unnecessary tests and services for themselves.
- The consumer does not decide to build unnecessary hospital beds.

- The consumer does not decide to keep beds on line that should be closed down.
- The consumer does not permit the continued existence of hospitals that should be closed.
- The consumer does not decide to acquire additional expensive equipment already available within the community.

4. Cost sharing has been shown to have almost no effect on the prices doctors and hospitals choose to place on their services. Providers decide the price of their services, not some free market.

5. The greatest increases in health care costs in recent years have been in the hospital sector. Yet patient cost sharing has been shown to have even less impact on use of hospital services than other kinds of health care.

6. Patient cost sharing discourages access to care by lower income persons. Study after study has shown that the burden of cost sharing falls inequitably on the poor, on blue collar workers, on minorities, and on those with large families.

The principal effect of patient cost sharing is to penalize consumers and to distract focus from the more politically difficult issue of holding our health care system accountable to public and consumer goals.

The proposed tax cap would generate revenues for the government and save money for employers at the expense of workers and retirees who would pay more in taxes and out-of-pocket payments when they receive health care.

A more constructive and effective approach to the problem of rising health care costs is to begin to reform the structure of the overall health care system. Ultimately such reform will be accomplished only under a comprehensive national health security program. In the short run, we favor an approach by which states would establish, within broad federal guidelines, "all payer" systems of prospective hospital reimbursement, negotiated fee schedules for doctors, and fixed diagnostic and laboratory fees. In addition, alternative forms of delivery, such as health maintenance organizations, should be encouraged.

A serious example of such an approach is the CHEC program developed by the Health Security Action Council, and introduced by Senator Kennedy (S.814) and Representative Shannon (H.R. 3261).

We urge this Committee to consider such legislation as a positive alternative to Administration proposals to tax the health benefits of workers' families. It would begin to get at the root of the problem by containing escalating health care costs in the overall health care system through reduction of inefficiencies and excessive profits which characterize much of the health care industry. This would be of great benefit to all payers for health care services, including the federal Medicare and Medicaid programs, as well as private employee health benefit plans.

Retirement Plans

Our Union is concerned about the trend toward favoring defined contribution plans at the expense of defined benefit plans. We believe this constitutes a serious public policy mistake.

Defined benefit plans meet workers' needs better than other retirement vehicles because they are based on a predictable retirement income. Since benefits can be increased based upon service already accrued, adjustments can be made to take account of inflation both for active employees and for retirees. Flexible funding arrangements allow these costs to be paid over reasonable periods of time.

In defined benefit plans, appropriate benefit levels can be provided in the event of disability even at younger ages. In defined contribution plans, on the other hand, the amount of the annuity payable to a worker disabled at a young age usually will be relatively low because of the small amount of money accumulated on the worker's behalf and the relatively long life expectancy he or she may have compared to other retirees. Defined benefit plans also have the flexibility to provide special or early retirement benefits on a basis more favorable than simply reducing the benefits actuarially for age, which is a useful feature in many situations. They also can be designed to provide incentives for employees to elect protection for their spouses if the worker dies before his or her spouse.

Defined benefit plans also place investment risk on the employer, who is generally more able to average it over lengthy periods of time or otherwise absorb losses than is an individual worker.

Defined benefit plans have recently been criticized because plan terminations have resulted in "broken promises". Some plan terminations have indeed resulted in reduced benefits for active and retired employees, although the PBGC provides substantial protections against loss or reduction of pensions. However, the projections made on behalf of defined contribution plans often are even more misleading. The promotions of IRAs, which often "promise" to make younger workers millionaires by retirement age, have downplayed the interest sensitivity of these projections and the impact that the inflation accompanying these interest rates would have on purchasing power. Unrealistic expectations engendered by such promotions represent a much more widespread problem than the questions raised by certain highly publicized defined benefit plan terminations.

A second concern we have with the encouragement of these new retirement vehicles is that they have resulted in a substantial revenue loss to the Treasury. At the same time that there is a mad scramble to raise revenue, Individual Retirement Accounts alone have accounted for an estimated $15 billion in lost revenues to the Treasury in 1982, nearly 10 times the anticipated loss. The revenue loss is expected to be almost as high for 1983.

While the development of salary reduction (401(k)) plans has been slower, substantial additional revenue losses can be anticipated as a result of these plans as well. The impact of these plans is also inequitable because they favor higher paid employees. In the pay reduction plans, only employees who have discretionary income will participate. These will typically be more highly paid employees.

The same is true for IRAs. It is anticipated that proportionately more than twice as many workers earning $50,000 or more contributed to IRAs as did workers earning between $20,000 and $50,000, and it is anticipated that 10 times as many workers earning over $50,000 contributed to IRAs as did those earning between $15,000 and $20,000. By contrast, coverage under employer sponsored pension plans is approximately the same for each of these groups (over $50,000: 89%; $20,000 to $50,000: 82%; $15,000 to $20,000: 79%, based on 1979 data from Employee Benefits Research Institute). This favored treatment of highly paid employees under the IRA and pay reduction managements runs counter to our concept of an equitable tax system and the more equitable treatment provided all employees under other employee benefit plans.

Other Fringe Benefits

The UAW also supports legislation introduced by Senator Packwood - the Employee Educational Assistance Extension Act (S.249) - which would make permanent provisions of the Internal Revenue Code excluding employer-provided educational assistance from taxable income. The UAW has a long history of negotiating employer-paid educational assistance programs. We believe such programs represent an important vehicle for promoting job retraining and career advancement for workers. The programs enable workers to acquire new skills essential in this rapidly-changing period of high technology. In addition, the programs play a key role in facilitating career advancement for minorities and women, such as entry into skilled trades jobs. Congress amended the Internal Revenue Code in 1978 to make such educational assistance programs tax free. But this provision will expire in December, 1983. This would have a damaging impact on the educational assistance programs currently in place, and would certainly prevent further expansion of such programs.

In addition, the UAW supports enactment of legislation to make permanent Section 120 of the Internal Revenue Code, which excludes employer contributions to prepaid legal service plans from taxable income. This provision was first passed in 1976 for five years, and then later extended in 1981 for three additional years. The UAW has long supported the development of prepaid legal service plans. We believe they represent the best vehicle for making quality, low-cost legal services available to working men and women. Traditionally legal services have been available only to the wealthy and the poor. The average middle class worker has been left out in the cold - unable to afford legal services on his or her own, but not able to qualify for government sponsored legal aid programs. In the last six years, the UAW has been successful in developing prepaid legal services plans covering approximately 600,000 active and retired Chrysler and General Motors employees, and their families. Our experience with these plans has been very positive: we have found that they are able to deliver quality legal services at a reasonable cost, and that there is a high level of utilization and satisfaction among the participants. Section 120 of the Internal Revenue Code is scheduled to expire in December, 1984. If this were allowed to happen, it would certainly discourage the development of other prepaid legal services plans, and could well have a harmful impact on existing plans. We therefore support efforts to make this provision of the Internal Revenue Code permanent.

Conclusion

This statement has not attempted to address the full range of fringe benefits; that is not feasible, especially since we have pointed out that the tax treatment of each should be based on the merits of the specific program. We hope that the Congress will make such evaluations in determining the tax treatment of fringe benefits, and will not merely view them as a convenient source of additional revenue. Well designed fringe benefit programs, such as child care, can provide desirable mechanisms and economies not otherwise available to most working people; they deserve to be encouraged by tax expenditures. On the other hand, fringes - such as incentive stock options - which merely shelter income for those who are already better off, and often pay less than their fair share of taxes, should not receive such favorable tax treatment. For these reasons, blanket approaches, such as presumption of taxability or a stringent annual dollar ceiling on the total cost of fringe benefits per employee are undesirable and inequitable because they fail to make such distinctions. We trust this Committee will be more discerning.

Again, we recognize the importance of the issues being addressed by this Committee. We thank the Committee for soliciting our views, which are based upon serious consideration and significant experience. We urge the Committee to reflect upon them in any actions relating to the tax status of various employee benefits.

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INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA—UAW

OWEN F. BIEBER, PRESIDENT   RAYMOND E. MAJERUS, SECRETARY-TREASURER

VICE PRESIDENTS

BILL CASSTEVENS • DONALD F. EPHLIN • ODESSA KOMER • MARC STEPP • ROBERT WHITE • STEPHEN P. YOKICH

June 21, 1983

IN REPLY REFER TO
1757 N STREET, N.W.
WASHINGTON, D.C. 20036
TELEPHONE: (202) 828-8500

The Honorable Robert J. Dole
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

Although it will not be possible for the UAW to testify at the hearing on June 23, 1983, concerning the proposed $700 "cap" on the third year of the personal income tax cut, we wish to state our strong support for this proposal. We ask that this communication be made part of the Finance Committee's hearing record.

Imposing a cap on the third year of the tax cut so that no taxpayer will receive more than $700 will have little or no impact on taxpayers with incomes below $45,000. They will still receive the full amount of the tax cut scheduled to go into effect on July 1, 1983. The only difference would be for the top 5 percent of taxpayers with incomes above $45,000, whose tax cut would be limited to a maximum of $700.

The UAW strongly opposed the Reagan tax cut when it was first proposed because we believed then, and still do, that it was badly misdirected and regressive in its application. In our judgment, it did not do enough for those who needed help the most and too much for those who needed it not at all. In the process, essential revenue has been denied to critically-important human needs programs, and deficits have risen to record levels.

The proposal to place a $700 cap on the third year of the tax cut would begin to address these problems. It would eliminate some of the unfairness in the tax cut. It would save $6 billion over the next year, and a total of $20 billion over three years. And, because most taxpayers would still receive the full amount of the tax cut, it would not reduce consumer demand or otherwise impede economic recovery.

The UAW therefore believes that the proposal to place a $700 cap on the third year of the tax cut represents sound fiscal policy. We believe it deserves the enthusiastic support of Congress.

Sincerely,

Dick Warden

Dick Warden
Legislative Director

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June 13, 1983

Senator Robert Dole
Chairman, Senate Finance
  Committee
Senate Office Building
Washington, D.C. 20510

Re: Hearings on Ceiling on Employer-Paid Medical Insurance

Dear Chairman:

Your committee will be considering a ceiling on deductions by employers for medical insurance provided to employees. If such a ceiling is considered to be appropriate it would be fair at the same time to eliminate a present inequity that has existed for many years. At present employees and persons who employ themselves through a corporation can receive an unlimited deduction for medical expenses if provided as employer-paid medical insurance. This is because the insurance payments are deductible by the employer and not income to the employee. The self-employed on the other hand can only deduct those expenses that exceed five percent (5%) of their adjusted gross income. There is no equity whatsoever in this difference just as there was none for the lack of parity of treatment of pension plans as between the employed and the self-employed for so many decades. I would urge the correction of this lack of parity. In addition to fairness, such a move would be one more step in the direction of eliminating reasons for incorporating for tax purposes.

Sincerely, yours,

Lawrence M. Stone

Lawrence M. Stone

LMS/pg

cc: Mr. John Chapoton
    Mr. Roderick De Arment ✓

NATIONAL ASSOCIATION OF INSURANCE BROKERS
311 First Street N.W. • Suite 700 • Washington, D.C. 20001 • Telephone (202)783-8880

July 7, 1983

The Honorable Robert Dole
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

Re: June 22, 1983, Hearing on S. 640
Comments Submitted for Inclusion in the Hearing Record

Dear Mr. Chairman:

The National Association of Insurance Brokers (NAIB) is firmly opposed to any proposal which would tax employee health benefits, because we believe such a tax would create significant and costly administrative burdens in employee benefit plans without generating the revenues it is intended to produce.

The NAIB represents major commercial insurance brokers in the United States. Our members develop the majority of the nation's business-related insurance coverages for clients ranging from large and small firms to public and private institutions of all kinds. NAIB members who specialize in the design and implementation of employee benefit programs -- developing insurance programs and related products as well as providing services needed to maintain self-insurance programs favored by many corporations today -- have reviewed this tax issue and have the following concerns.

If the law excluding amounts paid by employers for employee health benefits plans from taxable employee income is changed to place a ceiling on this exclusion, we believe a significant proportion of employers will restructure their benefit programs to avoid this new tax.

For instance, many firms are likely to ask for an employee contribution to cover costs over the tax cap and will then shift the remaining employer contribution dollars to another benefit that is not taxed. If this happened, no additional revenues would be produced. Experience of our members has shown that people are frightened by sky-rocketing hospital costs and want comprehensive protection. Thus, it is unrealistic to assume that the proposal would slow rising hospital costs through use of cheaper plans.

Such a tax could pose serious problems for employers with union negotiated contracts. If adopted, employees would not be receiving the same level of benefits for which they bargained due to the increased tax liability, yet employers would be paying the same amount in benefit costs.

Today, an estimated 35 per cent of employee health benefit plans are self-insured. The tax under consideration would pose another set of problems for companies with these plans. Generally, self-insurance programs are based on total costs rather than individual costs. To provide employees with the contribution information, self-insurers would be required to develop new information reporting systems and costly actuarial studies.

Finally, a tax on employee health benefits which sets a single national ceiling would fail to recognize geographic and age variations which affect health benefit costs. It would discriminate against employees in high medical cost areas and against older employees. At a minimum, virtually all employers would be forced to undertake in-depth and expensive reviews of the employee benefits packages.

The NAIB shares your concern over rising budget deficits and understands the need for review of various revenue-enhancing proposals. Nonetheless, because our members believe a tax on employee health benefits merely will result in a costly reordering of benefit programs without generating new revenues, I urge you to reject the proposal.

Sincerely,

Walter T. Derk
President

nea
NATIONAL EDUCATION ASSOCIATION • 1201 16th St., N.W., Washington, D C 20036 • (202) 833-4000
WILLARD H. McGUIRE, President
BERNIE FREITAG, Vice President
MARY HATWOOD FUTRELL, Secretary-Treasurer
DON CAMERON, Executive Director

STATEMENT OF
THE NATIONAL EDUCATION ASSOCIATION
ON
PROPOSED TAX CAP ON HEALTH BENEFITS
BEFORE THE
COMMITTEE ON FINANCE
OF THE
UNITED STATES SENATE

JUNE 22, 1983

For many years the National Education Association has vigorously supported legislation to bring about necessary reforms in health care--to provide quality services wherever they are needed, with special emphasis on preventive medicine and strict controls on costs.

We have done so because the American people are not getting their money's worth in health care. We spend more than $300 billion a year on health services, but those services are unevenly and inequitably distributed. The poor and the unemployed are notoriously underserved. The remedy, of course, is a comprehensive and universal national health insurance program. But we are far short of attaining that goal.

In fact, we are arguing about trickles in a flood of inequities. One such trickle is the Administration's preposterous proposal to put a tax cap on health benefits for those who are employed and whose employer puts up a part of the premium or enrollment costs in a health plan.

The immediate purpose of this proposal is to raise some cash. It's not a very good idea even for that purpose. Actuaries know that marketplace behaviour is very unpredictable, and that it does not necessarily follow that placing an arbitrary limit on the tax exemption for health benefits will raise any money at all. People--healthy, young people--may simply opt for lower-cost insurance, which means lower benefits and substantial risk-taking on their part. This group would pay no taxes at all on health benefits.

Those who are older and/or in failing or fragile health would probably choose to stay in a high-coverage plan. In addition to being sick, they would pay taxes on top of whatever coinsurance and deductibles might be part of their plan (even high-option plans have deductibles).

So the tax-raising measure would tax those with high health risks and encourage younger, healthier workers to take chances on their coverage. NEA views this proposal as an unwise and counterproductive tax device, and as a dangerous incentive to reduce health care benefits.

Some specific consequences of this proposal are immediately evident.

1. Taxing health insurance benefits could encourage employers to drop health benefits for workers who have been laid off. This would be a catastrophic blow to these workers.

2. The tax cap would be a disincentive to employers who might otherwise hire older workers or workers with health problems; the health benefit coverage costs would probably exceed the tax exempt amount for these workers.

3. Because of added costs of covering employees who are older or who have health problems, employers would be encouraged to force such workers to retire early--or simply to dismiss them.

NEA members--1.7 million employees in public schools and in the nation's colleges and universities--are among those who could be most seriously affected by the Administration's tax cap plan. They are unalterably opposed to such a plan, and want to convey to the Finance Committee their demand for greater, not lesser, tax equity and greater, not lesser, health care protection. The Association is convinced that there are better ways to contain health care costs than to place large segments of the working population at greater risk. One such means would be enactment of a health cost containment plan as advocated by the Committee for National Health Insurance. This plan would set the stage for meaningful and necessary reform in the delivery of health care and its financing. And unlike the Administration's various proposals to reduce federal assistance for social programs, it would start to make life better for the working American.

TAX SECTION
New York State Bar Association

[illegible]

June 13, 1983

Roderick A. DeArment, Esq.,
Chief Counsel,
Committee on Finance,
Room SD-221,
Dirksen Senate Office Bldg.,
Washington, D.C. 20510

Dear Mr. DeArment:

In connection with the Finance Committee hearing scheduled for June 22, I enclose copies of the Tax Section's 1982 report on the tax treatment of fringe benefits.

The report emphasizes the importance of preserving the integrity of the personal income tax base in formulating a system for the taxation of fringe benefits. This will require policy determinations, made on a comprehensive basis, as to which fringe benefits should be subject to tax. The taxation of fringe benefit will for the most part require legislation, although certain questions can be dealt with by regulation.

The report does not consider which specific fringe benefits should be subject to tax but suggests an approach to reporting and withholding for those fringe benefits which are determined to be taxable.

The report concludes that the inclusion of fringe benefits in the tax base will make it necessary to place responsibility for determining whether a benefit is taxable, and the measure of tax, upon the employer. It recommends that those fringe benefits which are determined by statute or regulation to be includible in income should, in general, be reported by the employer at the employer's cost, with certain

NYSBA

[illegible]

exceptions intended to preserve the right to show in an appropriate case that market value is lower or to prevent abuse.

Sincerely yours,

Willard B. Taylor

(Enclosure)

cc: John E. Chapoton, Esq.
Assistant Secretary for Tax Policy

Ronald A. Pearlman, Esq.
Deputy Assistant Secretary for Tax Policy

Robert Woodward, Esq.
Tax Legislative Counsel

David Brockway, Esq.
Chief of Staff
Joint Committee on Taxation

April 23, 1982

REPORT AND RECOMMENDATIONS OF COMMITTEE ON EMPLOYEE BENEFITS ON THE TAX TREATMENT OF FRINGE BENEFITS

Introduction

How remuneration for services which is paid in a form other than cash should be included within the personal income tax base is a problem which has dogged the income tax law since its inception. Numerous forms of fringe benefits clearly confer an economic benefit on employees by reason of the employment relationship. Some of such fringe benefits, such as tuition remission programs under which children of faculty members may attend the schools at which their parents teach without cost, or at reduced tuition cost, are not presently subjected to tax by reason of a long-standing IRS position; other fringe benefits, such as the utilization of company cars by employees, have been held to constitute compensation to particular employee-taxpayers, but the administration of the income tax as to such fringe benefits is not at all uniform.

The report was drafted principally by Arthur D. Sporn, with the assistance of Stuart Opotowsky and J. Roger Mentz. Helpful comments and suggestions were also received from Richard L. Alpern, Dianne Bennett, James B. Cheeks, Stanley Grubman, David Sachs, Michael Schler, Theresa B. Stuchiner and Willard B. Taylor.

The basic legal problem with the present state of affairs is that virtually all fringe benefits which confer an economic benefit on an employee clearly represent "gross income" subject to taxation under section 61 of the Internal Revenue Code.[1] As a legal matter, there is no doubt that tuition remission programs, free transportation for airline employees, and even free parking spaces constitute economic benefits to those recipient employees which may come within the statutory definition of "gross income".[2]

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[1] We do not include in this discussion the many employee benefits for which treatment is now expressly provided in the Code, such as group life insurance (section 79), medical expense reimbursement (section 105), accident and health insurance (section 106), group legal services (section 120), educational assistance programs (section 127), employee business gifts and awards (section 274(b)), and qualified retirement benefits (sections 401 et seq.). In each of these cases the favorable Code provision reflects a social policy judgment which Congress has already reached which takes them outside the scope of this report, and indeed outside the realm of fringe benefits whose tax treatment is currently under active consideration.

[2] See, e.g., Commissioner v. Glenshaw Glass Co., 348 U.S. 426 (1955); Commissioner v. LoBue, 351 U.S. 243 (1956); Commissioner v. Duberstein, 363 U.S. 278 (1960). See generally, Report on Discussion Draft of a Regulation to be Issued under Section 61 of the Internal Revenue Code, New York State Bar Association Tax Section (1975) (hereinafter the "1975 Report").

For numerous historical, practical or other reasons, however, many of these fringe benefits have gone untaxed, producing an uneven tax distinction between employees who enjoy such tax-free benefits, and employees who receive only taxable compensation. This distinction is not always between high-paid employees and low-paid employees, for in many cases the fringe benefit (e.g., airline transportation for employees of airline companies) is available to most of a company's employees, and in fact is a part of the compensation structure of the employer.

Current efforts to provide some uniform logical system of dealing with the myriad of fringe benefits can be regarded, perhaps somewhat arbitrarily, as commencing with the Proposed Regulations which the Treasury Department published on September 5, 1975.[3/] Though published only in the form of a Discussion Draft and accompanied by a Summary and Explanation which contained a thoughtful and penetrating analysis of the problems involved, the 1975 Proposed Regulations generated extensive controversy, and were withdrawn by outgoing Secretary of the Treasury

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[3/] Prop. Reg. §§1.61-2(d)(6), 1.61-16, 40 Fed. Reg. 4119 (Sept. 5, 1975) (hereinafter referred to as the "1975 Proposed Regulations").

William Simon a year after they were proposed. The commencement of further work by the Treasury Department on fringe benefit regulations in 1977 led to a Congressional moratorium "freezing" the issuance of new regulations initially until December 31, 1979;[4] the freeze was subsequently extended until May 31, 1981.[5] In January of 1981 Secretary Miller had sent Representative Rostenkowski a new discussion draft of proposed fringe benefit regulations, which had been prepared by the outgoing Administration.[6] The commencement of work by the new Administration looking to the issuance of new proposed regulations in the summer of 1981 produced a flurry of taxpayer and Congressional protest,[7] prompting a Treasury announcement that no new rules or regulations would be issued prior to July 1, 1982.[8] Section 801 of ERTA reinstated the statutory moratorium on fringe benefit regulations and extended it to December 31, 1983.

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[4] P.L. 95-427 (October 7, 1978).

[5] P.L. 96-167 (Dec. 29, 1979).

[6] See CCH 1981 Fed. Tax Rep. ¶8991 (hereinafter referred to as the "1981 Proposed Regulations").

[7] See, *e.g.*, 106 BNA DTR p. G-9 (June 3, 1981); 107 BNA DTR p. G-6 (June 4, 1981).

Leading Treasury Department officials, in requesting Congress last spring not to extend the freeze further, indicated their belief that the question can and should be dealt with largely by the promulgation of regulations.[9] As will be seen from this report, the Committee on Employee Benefits believes that the problem of bringing fringe benefits properly within the tax base goes considerably deeper, and that a workable solution requires substantial implementing legislation covering a considerable range of matters.

The Committee believes that the paramount consideration in formulating a system for the effective taxation of fringe benefits is preserving the integrity of the base for our personal income tax. This requires a series of policy determinations as to which fringe benefits should be subject to taxation. The Committee strongly urges that these policy determinations be made on a comprehensive basis which for the most part will require new legislation, although certain questions can obviously be dealt with by regulation. The subject of fringe benefits is so varied that the policy considerations can only be weighed effectively in the course of a comprehensive review of the subject.

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[8] See 16 BNA DTR p. G-2 (June 17, 1981).

[9] See Joint Statement by John E. Chapoton, Assistant Treasury Secretary for Tax Policy and Commissioner of Internal Revenue Roscoe L. Egger, Jr. at hearing by House Ways and Means Select Revenue Measures Subcommittee on Taxation of Fringe Benefits, May 13, 1981, 92 BNA DTR p. J-5 (May 13, 1981) (hereinafter referred to as the "Joint Statement").

Failure to adopt such a comprehensive approach will necessarily mean that fringe benefit issues will be decided on an ad hoc basis by the courts. The basic authority applicable to such cases, section 61 of the Code, mandates that "all income from whatever source derived" is subject to federal tax. Thus if the moratorium on the issuance of fringe benefit regulations continues to be extended indefinitely, and if Congress fails to enact legislation to deal with the taxation of fringe benefits on a comprehensive basis, the taxation of all fringe benefits will become potentially the subject of judicial determination on an ad hoc basis. The results of such judicial determinations are of course unpredictable; it seems likely that many fringe benefits will be held taxable under the broad statutory authority of section 61, but such a course of action will not be conducive to voluntary compliance or to effective administration of the tax laws.

We strongly recommend that such an ad hoc approach not be allowed to prevail, by default or otherwise, and the policy issues involved in the taxation of fringe benefits be considered comprehensively, by either Congress or the Treasury. This report is not, however, addressed to the policy issues as to which specific fringe benefits should be subject to tax or exempted from tax.[10/] The purpose of this report is to suggest an approach to information reporting and income tax withholding for those fringe benefits which are determined to be properly the subject of taxation. These administrative problems are of enormous significance in devising a sound and comprehensive scheme of taxation or nontaxation of fringe benefits. We believe that the subject of

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10/ We would anticipate the submission of an additional report or reports which would be responsive to specific legislative or regulatory proposals on this subject.

this report is an essential element in making the ultimate decisions as to which fringe benefits should be subjected to tax. Moreover, as will appear below, our recommendations strongly suggest the rules as to how one should measure the taxable amount of those benefits which are held to be taxable.

In order for any system of fringe benefit taxation to be uniform and effective in its application, not only must those fringe benefits which are includible in gross income be clearly identifiable; they must in fact end up as included in taxpayers' returns and with the tax paid thereon. As long as the personal income tax remains the backbone of our Federal revenue raising system, and personal service income continues as the largest component contributing to that tax, the need is pressing, and is underscored by the current deficit crisis.

The Committee is not aware of any authoritative estimates which have been published as to the total amount of fringe benefit income which currently goes unreported, but clearly it runs into billions of dollars per year, particularly if the shortfall is measured against the inclusive standard of includability in gross income which would be applicable under section 61. As such, the shortfall contributes a small but significant component to the revenue loss of approximately $62 billion which the Staff of the Senate Finance Committee recently estimated that the Government suffers as a result of the reporting and underreporting of legal income by individuals.[11/] But the importance of allowing fringe benefits to go untaxed goes beyond the direct revenue loss; in any taxing system which depends primarily upon voluntary compliance and self-assessment, there is a strong linkage between underreporting (and nonreporting) of income in one area and the failure by taxpayers to report income of other types. We believe it is not unlikely that the extent to which fringe benefit income goes unreported and untaxed, particularly in view of its highly conspicuous and widely publicized nature, is contributing to the growth of underreporting on items such as dividends, interest, and capital gains.

The Committee believes that the necessary and unavoidable key to placing fringe benefits soundly within the personal income tax base is to place responsibility

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[11/] See Statement by Senate Finance Committee Chairman Robert Dole, March 5, 1982, on proposed "Taxpayer Compliance Improvement Act of 1982", 44 BNA DTR p. J-1 (March 5, 1982). If the Treasury Department were to conduct a study providing a sound estimate of the probable extent of the fringe benefit revenue loss, such a study would undoubtedly contribute greatly to the general realization of the need to take remedial action.

for determining whether a benefit is taxable and, if so, its reportable amount, squarely upon the employer. This responsibility must of course be coupled with an employer obligation, enforceable by realistic and effective sanctions, to report the amount so determined to the Service and to the employee on his Form W-2, and possibly with a requirement of withholding, although the Committee is reluctant to recommend this final step at the present time.

Summary of Recommendations

To attain this objective the Committee recommends the following steps:

(1) The amount of those fringe benefits which are determined, by statute or regulation, to be includible in gross income should in general be reported by the employer at their cost to the employer. Such cost should be determined on an allocable rather than an incremental basis.

(2) The employer should be required to report the aggregate amount of an employee's taxable fringe benefits, determined as under (1) above, on the same W-2 reporting form on which the employee's cash wages and the tax held therefrom are included. Making this reporting obligation meaningful and enforceable requires the enactment of new civil sanctions addressed specifically to

underreporting or failure to report fringe benefit income. A meaningful civil penalty should be imposed for failure to report a taxable fringe benefit, unless the employer establishes reasonable cause for such failure.

(3) The Committee is reluctant to recommend the imposition of income tax withholding on non-cash benefits, at least unless and until a reporting system reinforced by meaningful sanctions has been tried and found wanting. While the administrative difficulties which are posed by withholding on dividends and interest would not be present if withholding were required on fringe benefits, the latter poses other, and formidable, administrative complications connected with the timing of withholding and with the fact that the employee receives no cash equivalent to the tax to be withheld; and these militate strongly against withholding except as a last resort.

(4) To avoid hardship and possible unfairness, an employee should be afforded the opportunity to demonstrate that a particular fringe benefit had a fair market value to him lower than the employer's cost at which it had been reported, and to be taxed at the lower figure.

(5) To avoid possible abuse of a cost measure rule, the nature and possibly the amount of benefits eligible for such treatment should be limited by statute. Benefits in kind which did not meet the statutory requirement should be taxable at fair market value, and subject to income tax withholding.

(6) Consideration for the very substantial burden which employers would be asked to shoulder under the program outlined above dictates that the rules covering each aspect of the program be formulated with an eye to minimizing employer trouble and expense in every way possible. In particular, (a) rules should be adopted which are realistic, if not generous, for excluding fringe benefits from taxable income entirely on a de minimis basis, and (b) to the extent that a benefit item is excluded from income under de minimis rules, the same rule should govern its exclusion from the FICA and FUTA wage bases.

1. Cost as the reportable amount of a non-cash benefit.

The Committee believes that the greatest stumbling block to the effective taxation of employee fringe benefits has been the problem of valuation. Generally speaking, where income is realized in kind, the amount to be taken into income under our tax laws has been measured by the fair market value of the property received (or of the other benefit conferred upon the recipient). However, most thoughtful analysis of the fringe benefit area has recognized that the problem of valuing most employee benefits is "extremely difficult",[12] if not "monumental",[13] and "vastly complicates the tax law."[14] In recent years, as our economy has grown more and more complex, competitive, and deregulated, the difficulties of determining fair market value have increased to a point where not only is it virtually impossible to impose a strict obligation to determine such value on the employer, but imposing a fair market value measure of income is virtually guaranteed to breed controversy as to the employee's tax liability.[15]

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[12] See, *e.g.*, item 4 under Policy Considerations in the Discussion of the 1975 Proposed Regulations.

[13] *Cf*. Greif, "Analysis of Treasury Proposals on Fringe Benefits", 45 J. of Taxation 96 (1976).

[14] See note 12, *supra*.

[15] Employers are widely concerned about becoming embroiled in controversies as to their employees' tax liabilities, and the detrimental effect of such involvement upon good employer-employee relations. See, e.g., 105 BNA DTR p. G-4 (June 7, 1981) (testimony and comment on Service's W-4 proposals).

The example of the executive's wife who accompanies him on the corporate jet, resulting in his tax liability for the cost of a first class airline ticket between the points in question,[16/] illustrates the difficulty of applying the fair market value standard, for in today's deregulated market one often encounters a considerable variation in the prices different carriers charge for a first class flight between two given points. To take another case, it might seem that the simplest case of a readily ascertainable fair market value would be the purchase of merchandise at a discount by the employee of a retail store; but what would one make of the taxpayer employee who asserted that while he gladly purchased the item in question from his employer at a discount of 25%, it was identical (or virtually identical) with merchandise which a competitor was selling at a price 20% below the employer's retail price?

A realization of these difficulties in determining fair market value led the American Institute of Certified Public Accountants, in its 1979 report on Fringe Benefits,

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[16/] See, e.g., Example (3) of §1.61-20(c) of the 1981 Proposed Regulations.

to recommend employer cost (or fair market value if less) as the measure of taxable income.[17]

The Committee subscribes to this recommendation, primarily on the ground that we believe that cost, with all of its complexities and shortcomings,[18] is the only basis on which it is feasible to impose upon employers a strict obligation to determine and report fringe benefit income. We believe that this consideration far outweighs the importance of the fact that fair market value may be an inherently more accurate measure in a notional sense of the income realized, although it should be recognized that in the fringe benefit area fair market value suffers from serious deficiencies as the measure of income, even as a theoretical matter.

The inherent infirmity of fair market value as a measure of fringe benefit income arises from the fact that the concept assumes a freedom of choice on the part of the recipient; i.e., that the recipient given cash would use it to purchase the item in question. There must, in other words, be a "willing buyer . . . [not] under any compulsion to buy . . . and . . . having knowledge of relevant facts."[19] Here again, the case of executive's spouse taking the corporate jet points up the unsoundness of the test. Even if one assumes that the price of a comparable first class airline flight between the two given points can be ascertained without undue difficulty, what consideration should be given to whether the spouse, given a choice, might not in fact take a tourist seat on a puddle-jumping, night-owl flight, rather than the first class ticket, and pocket the cash difference?

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[17] See Federal Taxation Division of American Institute of Certified Public Accountants, "Fringe Benefits: A Proposal for the Future," (April, 1979), p. 7 (hereinafter referred to as the "AICPA 1979 Proposal").

[18] We recognize, for example, that cost has the drawback that employees with different employers may be assigned different amounts of income for substantially the same benefit. The relief measure proposed on page 30 below might in some cases mitigate discrepancies of this sort.

A growing realization of the shortcomings of the fair market value test has led to the concession by its proponents that some discount or modification may be in order,[20] if not imperative, and that perhaps even a

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[19] Cf. Reg. §20.2031-1(b).

[20] See, e.g., Joint Statement, supra note 9; Cf. Testimony of Donald C. Lubick, Assistant Secretary of the Treasury, before Ways and Means Committee Task Force on Fringe Benefits, 124 Cong. Rec. H. 8697 (August 15, 1978).

"subjective" value to the recipient might be considered for tax purposes. Any such system of discounting or other modifications would add further complexity and uncertainty to the already knotty and controversial question of deciding how to fix the fair market value which is to be taken as the starting point. The Committee's 1975 Report suggested a more direct and workable solution; in pointing out the impossibility of arriving at a fair market value for many benefits, it suggested that employer cost might be taken as a reasonable approximation of the same.[21]

The importance of a workable and enforceable employer reporting obligation, taken in combination with the difficulties and inherent shortcomings of fair market value as an alternative to cost, has led the Committee to its recommendation that the taxable amount of fringe benefits should be fixed for the most part at employer cost.[22] It is essential that an employer's reporting obligation be uniform, and that the amounts be determinable from its own business records. Thus it is far fairer and more practical to ask the employer to come up with a figure representing its cost[23] rather than to assume the administrative burden of determining fair market value, discounted or otherwise, for purposes of reporting to the employee.

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[21] See the 1975 Report at p. 27.

[22] The use of cost as the general measure might require escape provisions to prevent its imposing hardship, discussed at page 30 *et seq*. below, and also requires safeguards against abuse, discussed at page 32 *et seq*. below.

This approach of imposing no more than a fair reporting obligation on the employer is consistent with the basic thrust of the Supreme Court's decision in Central Illinois Public Service Co. v. United States, 435 U.S. 21 (1978). In Central Illinois the Court held an employer not liable for withholding taxes on amounts paid to employees for certain business-related traveling expenses which were of the type previously held to constitute taxable income under Commissioner v. Kowalski, 434 U.S. 77 (1977). In Central Illinois the Court made a special point that the employer's obligation to report and withhold must be precise and not speculative, for otherwise the employer would be unfairly burdened. In a similar manner, it would be an unfair burden to require an employer to report income to its employees on a basis not susceptible of clear determination by the employer, and to impose penalties for noncompliance. Thus the most reasonable reporting requirement for an employer is cost, an amount which the employer is capable of determining from its own records.

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[23] In many cases the employer will already be under the necessity of determining the costs of employee benefits (or related costs from which such figures can readily be derived) for various non-tax reporting and other business purposes.

If the employer's cost is to be accepted as fixing the reportable amount of those fringe benefits which are taxable, we believe it is important that allocated cost rather than incremental or additional cost should be adopted as the generally controlling measure. Allocated cost should not only be generally less troublesome for the employer to determine, it is also preferable in that in most cases it offers a far closer approximation to the value of the benefit conferred; in many instances the incremental cost of furnishing an employee with goods and services of very substantial value will be minimal. The AICPA 1979 Proposal recommends without discussion (page 7) the general use of incremental cost, but then goes on to provide an exception for allocated cost "when property is furnished to employees primarily for personal use." No reason is suggested however why such a different rule should apply to benefits in the form of property (goods) as distinguished from facilities and services (assuming such a distinction was intended), and the exception as thus stated seems so broad as virtually to swallow up the rule of first instance.[24/]

The Committee subscribes to the generally recognized view that as a matter of policy where a benefit can be provided at minimal incremental cost, this may be one of the factors entering into a decision whether to exclude it from income entirely, but only under carefully circumscribed conditions, such as where the benefit is furnished in the normal course of the employer's business, and where it is made available to employees generally, or to a reasonable classification of employees which is related to factors

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[24/] The fact that the Securities and Exchange Commission prescribes "aggregate actual incremental costs" for reporting management remuneration which is paid in the form of personal benefits not directly related to job performance is believed to be of no persuasive force as a precedent for a workable system of tax administration. Incremental cost may well be the more significant item, as a disclosure matter, from the point of view of corporate stockholders even if it is a less accurate measure of the value the executive is receiving. Moreover, the SEC rule also contains a major qualification where "aggregate costs are significantly less than the aggregate amounts the recipient would have had to pay to obtain the benefits." In such a case, the SEC requires the value to the recipient either to be disclosed in a footnote or to be substituted in toto for incremental cost, an approach which may be workable for purposes of disclosure reporting, but is obviously totally impractical for tax administration. See SEC Regulation S-K, Item 4(a), Instruction 2(d)(1).

such as seniority or nature of work and which does not result in limiting the eligible group to highly compensated employees.[25] If however an item does not qualify for complete exclusion under the strict requirements of such an exclusionary rule (assuming it is accepted by the policy-deciding body, i.e., Treasury or Congress), allocated rather than incremental cost should become the measure of the amount of income reportable.

2. Inclusion of fringe benefits in information returns.

Bringing fringe benefits effectively within the personal income tax base requires readily comprehensible, workable rules for determining their taxability and the measure thereof, which employers can reasonably be required to apply; this is believed to be the principal argument in favor of cost as the basic measuring rod. In addition, if taxes on fringe benefit income are actually to be collected, the employer's obligation to determine and report such income must be a meaningful one.

The present sanctions for failure to include fringe benefit income in the information return reporting taxable compensation are woefully inadequate. The only civil provision in the Code which appears literally applicable is section 6652(b), and even this is literally applicable only to a failure to file in toto.[26/] There are various criminal penalties prescribed by the Code for willfully filing false or fraudulent returns,[27/] which in theory are potentially applicable, but as a means of effective enforcement these represent an obvious case of overkill.

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[25] See, e.g., §1.61-16(a) of the 1975 Proposed Regulations; page 4 of the 1979 AICPA Proposal.

The Committee believes that an effective inducement to employers to take the trouble of determining and reporting taxable fringe benefits requires a new statute specifically addressed to the subject, which would pro-

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26/ The penalty prescribed under section 6652(b) is "$1 for each . . . statement not so filed," up to a maximum of $1,000 per annum. In addition, section 6674 prescribes a penalty of $50, but only for an employer who "willfully furnishes a false or fraudulent statement" or "willfully fails to furnish a statement . . . showing the information required [as to taxable wages] under section 6051 . . ." to his employee. Moreover, to the extent that taxable fringe benefits did not constitute "wages" under section 3401(a), it seems doubtful that even their willful omission from a Form W-2 would be subject to penalty under this provision, despite the Service's insistence in Rev. Proc. 80-53, infra note 30, that they must be included in a W-2 given to the employee.

27/ See, e.g. sections 7203, 7206(1) and (2), and 7207.

vide a form of civil penalty for failure to report such taxable amounts unless the employer established reasonable cause for such failure. The amount of the penalty should be related to the amount unreported or underreported, presumably a percentage thereof, with a dollar minimum in a substantial amount, and perhaps a dollar maximum. Another possibility would be simply to disallow a deduction to the employer for costs attributable to taxable fringe benefits which were not properly reported on Forms W-2.[28/] On balance, however, the Committee believes that a civil penalty would be distinctly preferable as a sanction to deduction disallowance. The latter suffers from unevenness in its application, depending on the employer's tax rate (and might even furnish no deterrent to a loss employer), and could also pose greater administrative difficulties in isolating the costs to be disallowed.

If employers are to be required to go to the

[28/] *Cf*. sections 274(e)(3) and (10), which in effect require that amounts expended to provide entertainment or recreation for employees and independent contractors be included in information returns furnished the recipient if the taxpayer making the expenditures is to obtain a deduction for such amounts.

trouble and expense of fixing the amounts of those fringe benefits which are determined to be taxable, and of reporting the amounts so fixed, the reporting procedure should be such as to maximize the likelihood that these amounts will in fact end up included in gross income on employee returns. The Regulations have long taken the position that all payments of compensation, whether or not paid in cash and whether or not they constitute wages, must be reported on Form W-2, but have permitted the reporting of different components of these amounts on separate Forms W-2 at the employer's election.[29/] At the end of 1980 the Service issued Rev. Proc. 80-53[30/] and News Release IR 80-133 (December 31, 1980), in effect reaffirming its position that taxable fringe benefits must be reported on Form W-2 whether or not they constitute wages, and confirming the permissibility of a separate Form W-2 for the fringe benefit component.

The Committee believes that the possibility that an employee may disregard information returns

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[29/] See Reg. §1.6041-2. See also Reg. §1.6052-1(a)(1), permitting the use of a separate Form W-2 for reporting the taxable element of group life insurance premiums paid by the employer.

[30/] 1980-2 Cum. Bull. 848.

advising him of his taxable fringe benefits would be greatly reduced if this information was included on the same Form W-2 which listed his wages, which must of course be attached to his return in order to claim credit for the taxes withheld. Such a requirement would presumably require a redesign of Form W-2, but this trouble, and even any additional trouble and expense which employers might have to incur in employing the single return format, would seem amply repaid in increasing the likelihood that taxable fringe benefit income will actually be reported by the employee receiving it.

The need for the employer to calculate the amount of fringe benefits to be included would seem to dictate some relaxation of the present time requirements for furnishing Form W-2 to employees, in particular to terminating employees.[31/] A statutory amendment might extend the time for furnishing all Forms W-2 which included non-cash remuneration from January 31 to February

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[31/] See section 6051(a); Reg. §31.6051-1(d)(1). H.R. 4717, as amended and passed by the Senate, would amend section 6051 to give an employer up to January 31 of the following year to furnish a Form W-2 to a terminated employee, unless the employee requests an earlier receipt. See 34 BNA DTR J-5 (February 19, 1982).

15, or at least provide for the ready granting of 15-day extensions on application. A February 15 deadline would still give the employee two full months after receiving his Form W-2 in which to prepare and file his own return, and thus should not interfere unduly with timely employee filings.

3. Income tax withholding on fringe benefits.

The Committee has considered the desirability of requiring that taxable fringe benefits be included in the wage base on which income tax must be withheld. While arguments in favor of withholding can be advanced, and it might in fact ultimately prove necessary as a matter of last resort, we are highly reluctant to recommend it at this time in view of the very formidable administrative difficulties which withholding would involve and the disruption, and possibly even hardship, to employees which might occur in certain cases.

The administrative difficulties posed by withholding on non-cash compensation are not those which would be involved in withholding on dividends and interest, which has been widely debated in recent years, and which the Administration is proposing once more. The administrative difficulties connected with interest and dividend withholding center on the multiplicity of payors involved, parties who in many cases have only the most tenuous contacts with their payees, together with the fact that in many cases withholding in any amount on dividends or interest would be overwithholding, and this could result in real hardship to payees unless a system of exemptions or of providing refunds on an interim basis were established. None of these difficulties applies to withholding by an employer, but here withholding on non-cash remuneration raises other administrative problems.

In order to be least objectionable, withholding would have to be imposed at the time the non-cash benefits were conferred and enjoyed, and one must always assume the concurrent receipt of cash compensation from which the tax could be withheld. Delayed withholding would be a source of disruption and possibly even hardship to many employees. Concurrent withholding, or even withholding shortly after benefits were conferred, would in most cases be an impossibility if the presumptive measure of taxable income is to be employer cost, as the Committee recommends (indeed, withholding concurrently or shortly after realization would pose a formidable problem even if the measure of taxable income were to be fair market value or some modification thereof). Postponement of withholding until after the end of the taxable year, as would be essential in many cases under a cost measure rule, raises difficult timing problems even with continuing employees if they are to claim the amounts withheld as credits against their tax for the year just closed. For employees whose employment had terminated at or prior to the end of the year, there would be a virtually insoluble problem of finding a source of funds from which the amounts could be withheld.

A realization of these difficulties undoubtedly led the AICPA in its 1979 Proposal to recommend (page 8) that no withholding be required, so as "to minimize employer's administrative problems . . ."; and the Committee concurs in this view. Moreover, we believe it would be particularly feasible to dispense with withholding, and to employ cost as the presumptive measure of taxable income, if the benefits to be governed by these rules were limited in nature and also in amount, as discussed under point 5 below, and if non-cash compensation which did not qualify for these rules were made includible in income on the basis of fair market value and also made subject to withholding, as might be accomplished by means of a statutory extension of section 83.

Essentially the same administrative difficulties which militate against withholding dictate that fringe benefit income should not have to be reckoned with by an employee in determining his estimated tax obligations. It should therefore be expressly exclued from the gross and taxable income on which the employee's obligation to file declarations of estimated and to pay estimated tax installments are based, and sections 6015, 6153, and 6654 should be amended accordingly.

It should be stressed that the Committee's recommendation against withholding at this time is conditioned upon granting a fair trial to a reporting system such as recommended, and upon its achieving reasonably successful results. If information returns are to be afforded a reasonable chance of success, not only must employers cooperate in undertaking the trouble and expense of compiling them, but the Service must also be afforded the resources to process and monitor the additional information it will receive and to undertake audit and enforcement action which this information suggests. It is clear that the present resources of the Service are already stretched far too thin to make it reasonable to expect it to shoulder this further undertaking unless it receives additional appropriations to equip and staff the project.[32] And we strongly recommend that the necessary funds be appropriated. Solely from the point of view of Government expenditures, it is obvious that withholding would be a considerably less costly method of bringing in additional revenues based upon fringe benefit income.

4. Avoidance of hardship where the cost of a fringe benefit exceeds its fair market value.

If cost is adopted as the presumptive taxable amount of a fringe benefit which is taxable, cases may arise where this amount is actually in excess of the fair market value at which the employee could purchase the benefit. One example of a widely furnished benefit which may fall into this category is afforded by tuition remission programs, under which the children of faculty members may attend the schools at which their parents teach, or other schools participating in the program under reciprocal arrangements, on a tuition free basis;[33] for many educational institutions the cost of enrolling a student for the year exceeds the tuition charged. The cost of a flight on the employer's plane (where held taxable) will often exceed the cost of even a first class ticket on a commercial airline.[34] For the most part, however, it is believed that cases where the cost of a benefit will exceed its fair market value will be comparatively rare.

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[32] See Statement of William J. Anderson, Director, General Government Division, General Accounting Office, before the Subcommittee on Commerce, Consumer and Monetary Affairs of the House Committee on Government Operations, March 17, 1982; Statement of Senate Finance Committee Chairman Robert Dole, *supra*, note 11.

[33] See Sections 1.117-3(a) and 1.61-17(c) and (d), Example 2, of the 1981 Proposed Regulations. The Committee expresses no opinion as to whether or not benefits under such tuition remission programs should be made taxable.

There should be no objection to allowing an employee to reduce his tax liability if he were willing and able to shoulder the burden of proof in showing that the fair market value was indeed less than the employer's cost -- the amount at which it would be reflected on his Form W-2. Consideration might even be given to permitting an employee to demonstrate that the benefit had an actual value to him less than its fair market value -- as where a lower priced substitute (perhaps a tourist class night flight) was available which the employee would have selected if given a free choice.[35] Any such relief if afforded should be contingent upon a more exacting burden of proof requiring the employee to establish actual value, if lower than fair market value, by a clear preponderance of the evidence. We believe that the paramount consideration is that none of these relief alternatives should be permitted to complicate the employer's task and responsibility.

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[34] See, e.g., Ireland v. United States, 621 F.2d 731 (5th Cir. 1980).

[35] Cf. Reginald Turner, 13 T.C.M. 462 (1954).

As a general rule these should be limited to determining whether the benefit the employer is providing is taxable, and if so his cost in furnishing the same. Since the overriding consideration is to minimize employer trouble and expense to the greatest extent compatible with the reporting of those fringe benefits which are taxable, consideration might, however, be given to authorizing the Service to entertain and approve applications by employer groups to base their reporting obligation upon fair market value, rather than cost, in cases where the former was both lower and easier to ascertain. Such an option might, for example, be of importance to colleges and other schools, assuming a policy decision were reached to make some or all tuition remission programs taxable.

5. Preventing abuses of cost as the measure of income derived from non-cash benefits.

Adopting employer cost as the measure of taxable income in the fringe benefit area would raise a possibility of abuse. If promulgated without qualification, such a rule might lead to arrangements hand tailored between an employer and a key executive (or, possibly, a very limited group of key employees) under which a very substantial portion of the employee's total compensation was paid to him in kind, at a cost to the employer far below what the employee would have to pay for the benefits on the open market. While cases of such abuse might be comparatively rare, it would be important for the integrity of the tax system to establish their ineligiblity for the fringe benefit treatment here under discussion.

The Committee believes that the way to restrict or eliminate such abuse would be to draw a line between fringe benefits which were eligible for taxation at cost, and eligible for information reporting rather than withholding treatment, and those benefits which were not. One ready means of accomplishing this result would be by expanding and clarifying section 83 so as to bring the ineligible benefits expressly within its ambit.

At the outset it should be pointed out that the drawing of a line between section 83 property and the great bulk of fringe benefits of the conventional type is long overdue. Thus, shortly after section 83 was added to the Code in the Tax Reform Act of 1969 the Tax Section of the New York State Bar Association, as well as many others, pointed out in submissions to the Service that literally read the new statute applied to all property transferred in connection with the performance of services. We urged the Service to interpret section 83 as applicable only to property transferred subject to a restriction, or at least to confirm that it was inapplicable to items such as courtesy discounts and seasonal gratuities which had long been disregarded on de minimis principles.[36] The section 83 Regulations both as proposed and as finally promulgated made no mention of the subject, and the question of whether and to what extent fringe benefits such as those under discussion are taxable under section 83 has largely been ignored.[37]

36/ See the Committee's 1970 Summary of Recommendations for Regulations under Provisions of the Tax Reform Act of 1969 Affecting Employee Benefits; Report of Committee on Employee Benefits on Proposed Regulations Dealing with the Treatment of Property Transferred in Connection with Performance of Services, transmitted to the Commissioner on July 19, 1971.

37/ The Treasury Department's 1981 Discussion Draft of Proposed Regulations at least recognized the interrelation of the taxability of the fringe benefits with which it deals and taxability under section 83. It provided a proposed amendment to Reg. §1.83-1(a) to include a cross reference to its proposed new fringe benefit rules, but did not further elaborate on the subject.

The Committee recommends that legislation be enacted providing that the non-cash benefits to be taxed at cost are only those which are furnished incidental to the employer's business.[38/] The Committee also recommends that the possibility of abuse be further limited by restricting fringe benefits eligible for taxation at cost to a maximum dollar amount, perhaps $10,000 or $15,000 per employee per annum. Any such statutory maximum should include a provision for subsequent adjustment to take into account changes in the cost of living. The maximum might, for example, be set at one half of the then current Social Security wage base. The dollar maximum might also be combined with a percentage limit, as is now frequently done in the taxation of employee benefits.

The legislation we recommend would expressly provide that non-cash benefits which did not meet the requirement of being furnished incidental to the employer's business, or which exceeded the statutory

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[38/] For example, an employer whose business did not require the use of automobiles could not maintain a service station at which gas and servicing were furnished to his employees' cars at no cost, or at bargain rates.

maximum, were to be taxed pursuant to section 83. Section 83 in turn would be amended concurrently to provide that it was applicable to all goods and facilities furnished, as well as to property transferred, to an employee in connection with the performance of services, except to the extent that they were taxable at cost under the fringe benefit rule. To the extent that benefits fell within the ambit of new section 83, the measure of their taxable amount would of course be fair market value, and they would be subject to the income tax withholding requirements of Reg. §1.83-6(a)(2).[39]

6. Minimizing the employer's reporting burden.

The Committee recognizes that a bona fide and meaningful attempt by employers to comply with the system proposed herein would entail substantial additional trouble and expense for many employers.[40] If employers are to be asked to shoulder this burden, consideration for them dictates that the reporting rules adopted should not increase it more than is strictly necessary. The objective of fringe benefit reform is primarily the practical one of bringing substantial amounts of currently unreported income into the income tax base, and requirements which do not contribute significantly to this end, or which entail expense out of proportion to the contribution they make, should be avoided.

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[39] The provision in the Regulation denying the employer his business deduction if he fails to deduct and withhold from the employee has been criticized and questioned. However, an employer who failed to deduct and withhold the tax on non-cash remuneration where it was required would also be potentially liable for the tax itself under section 3403 and for penalty under section 6672.

If any doubt might be present as to the employer's obligation to deduct and withhold tax under section 83 as we recommend that it be amended, the Committee recommends that such doubt be eliminated as part of the amending legislation proposed.

One key to minimizing the reporting burden is, clearly, the formulation of sensible and fairly liberal rules for exclusion of taxable, or arguably taxable, items on a de minimis basis. The Committee subscribes to the general principles proposed in the AICPA 1979 Proposal[41] that a de minimis exclusion should be extended to an item if it either

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[40] This is so even though the proposed requirements are not significantly more onerous than those currently applicable to employers in theory, under Reg. §1.6041-2 and Rev. Proc. 80-53, *supra* note 30.

[41] See page 4 of the 1979 AICPA Proposal; *Cf*. Section 1.61-16(c) of the 1975 Proposed Regulations.

(a) involves only the incidental personal use of a facility or asset whose primary purpose and use is business related, or

(b) is so small or unidentifiable as to make accounting for it unreasonable or administratively impractical.

Application of these general principles to specific cases must await a policy determination as to the nature and types of fringe benefits which are to be generally taxable -- preferably on the comprehensive basis recommended above. We strongly recommend that whatever specific de minimis rules are adopted should include, wherever possible, dollar thresholds which are as generous as the Treasury considers to be compatible with the admitted possibilities which such thresholds may offer for abuse and revenue loss. We also recommend that where a de minimis rule includes a threshold exclusion, it should further provide that where the stipulated threshold is exceeded, only the excess is taxable,[42/] particularly in cases where threshold limits

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[42/] Compare Examples 3(ii) and 5 of Section 1.61-19(c) of the 1981 Proposed Regulations, which would have made the entire amount of the item taxable once the threshold limit was exceeded.

are set for transactions on a cumulative annual basis.[43]

Finally we believe that minimization of employer trouble and administrative expense dictates that, to the extent that non-cash benefits are excluded from taxable income under de minimis rules, the same rules should apply to exclude them from the FICA-FUTA wage base. While the desirability of uniform income tax, FICA, and FUTA treatment, as a general proposition, seems obvious,[44] it must also be recognized that the treatment of non-cash remuneration under the FICA and FUTA taxes involves other considerations. FICA in particular can be administered only on the basis of withholding; in addition, the question of the extent to which various items should (or must) be included in the FICA tax base raises issues as to the fiscal soundness of the Social Security system which are beyond the scope of this report.

But even if allowance for possible differences is made, in the case of benefits excluded from income on a de minimis basis, the revenue implications of exclusion under any of the three taxes cannot be very great. Accordingly, it is believed to be important, and not subject to controversy, that the same de minimis rules, at least, should apply to exclusions under all three taxes.

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[43] Compare Example 2(ii) of Section 1.16-19(c) of the 1981 Proposed Regulations.

[44] *Cf*. *Rowan Companies, Inc*. v. *United States*, 81-1 USTC ¶9479, p. 87410 (1981).

CONCLUSION

An effective program for bringing employee fringe benefits into the personal income tax base requires the taking of the following steps:

(a) A comprehensive policy review to determine which fringe benefits are to be made (or to remain) subject to taxation; and

(b) A thorough overhaul of the present administrative mechanism for reporting those fringe benefits which it is determined should be taxable.

Part (a) of such a program would include both promulgating general standards for includibility and (very probably) prescribing specific treatment for certain economically important benefits which are widespread in particular industries, as well as the formulation of sensible de minimis exclusionary rules. It seems clear that Congress should -- indeed would have to -- play a very substantial role in this part of the program.

To implement part (b) of such a program, which is the principal subject of this report, the Committee recommends

(i) the enactment of legislation establishing that those fringe benefits which are determined to be taxable are, in general, to be taxed to employees at their allocated cost to the employer;

(ii) that employers be required to report the amounts of taxable fringe benefits, as so determined, on the same Form W-2 which furnishes information as to the employee's cash wages (and the tax withheld therefrom), and that new sanctions be enacted imposing meaningful civil penalties for unexcused failure to report fringe benefit income;

(iii) that consideration of requiring the withholding of income tax from fringe benefit income be deferred until the efficacy of a reporting system such as that recommended herein has been tested, and that the Service be afforded appropriations adequate to insure a fair trial of the system;

(iv) that the employee be afforded the opportunity to demonstrate that a fringe benefit which he accepts has a fair market value to him which is lower than his employer's cost at which it has been reported, and in such cases to be taxed at the lower amount;

(v) that a statutory limitation be imposed on the nature and, probably, the amount of benefits which are eligible for taxation at cost, with provision that benefits which do not meet these requirements are to be taxable at fair market value and subject to income tax withholding; and

(vi) that the employer's reporting burden be minimized in every reasonable manner, including the establishment of realistic de minimis exclusionary rules which are to be applicable not only for income tax but also for FICA and FUTA tax purposes.

STATEMENT OF
THE RETAIL TAX COMMITTEE OF COMMON INTEREST
SUBMITTED TO
THE COMMITTEE ON FINANCE
UNITED STATES SENATE
"Taxation of Fringe Benefits: Retail Store Discounts"
June 22, 1983

Introduction

The Retail Tax Committee of Common Interest represents nine major retailing companies,* the American Retail Federation, and the National Retail Merchants Association on federal tax matters that are of interest to the retailing sector of the economy. Retail sales represent approximately 33 percent of the GNP and provide jobs for 12 million full-time employees and a large number of part-time employees.

This statement presents the retail sector's views that the store discount is a non-compensatory benefit that should not be subject to federal income taxation.

Summary of the Issue and Recommendation

Taxation of noncash benefits as compensation to employees has long been been a complex issue in federal income tax policy. For six years, Congress has prohibited regulatory actions that would revise the generally understood and longstanding rules applied to fringe benefits. The primary concern of retailers in this area is the treatment of product discounts. Rather than being treated as compensation, these discounts encourage business in the store and are an important means of modeling and advertising merchandise sold by the company and educating employees about the products. Taxing fringe benefits such as merchandise discounts would present massive administration and valuation problems. Such discounts should not be taxed.

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* Allied Stores Corporation; Associated Dry Goods Corporation; Carter Hawley Hale Stores; The Dayton Hudson Corporation; Federated Department Stores, Inc. R. H. Macy & Company, Inc.; The May Department Stores Company; J. C. Penney Company, Inc.; Sears Roebuck and Company.

The Issue and Background

The term "fringe benefits" generally refers to those noncash benefits received by employees in connection with their employment. There are a great variety of such benefits, and the particular mix depends heavily on the nature of the line of business as well as the particular attitudes of managers and employees of a given company or industry. An item of primary concern to the retail sector is the retail store's discount on products purchased by employees.

In September 1975, the Treasury Department issued a discussion draft of proposed regulation intended to govern the tax status of fringe benefits. The stated purpose was to provide comprehensive guidelines that would afford greater degrees of certainty, uniformity, and fairness in the tax treatment of employer-furnished benefits.

Numerous comments were submitted on the discussion draft. Many attacked the proposal as being too strict because certain types of fringe benefits, not theretofore regarded as taxable, would have been treated as such in the future. Others attacked it as being too generous, i.e., for exempting too many varieties of fringe benefits from taxation. The result was the withdrawal by the Treasury of the discussion draft in December 1976.

The commencement of further work by the Treasury Department on fringe benefit regulations in 1977 prompted legislation that directed the Treasury and the IRS not to issue new regulations on the taxation of fringe benefits prior to January 1, 1980. Congress also had initiated a more serious effort to deal with the fringe benefit problem. A Special Task Force on Employee Fringe Benefits was established by the House Ways and Means Committee, and hearings were held by the Task Force in August 1978. However, this effort lost momentum, apparently as a result of both the technical complexity and the political sensitivity of the subject matter. The result was another extension of the moratorium until June 1, 1981 and, most recently, through December 31, 1983.

Product Discounts

Of great importance to the retail industry is the product discount allowed to retail store employees. Since most general merchandise retailers have discount policies and the industry employs over 15 million people, a significant number of people would be adversely affected by a change in the longstanding policy affecting this single benefit.

Product discounts have not been taxed since the income tax was first enacted in 1913. In fact, employee discounts have not been considered compensatory in nature because they are not intended to be, nor are they viewed by retailing employees as, payments for their services. Indeed, the value of a discount policy to any individual employee bears no relationship to the services performed. Instead it depends on a number of completely unrelated factors such as the employee's consumption pattern, the number of dependents in the family, the quality of merchandise in the store, the type of merchandise in the store, among others. One reason for avoiding a tax on product discounts is that a logical extension would be to tax the "bargain" element in a discounted item sold to a non-employee.

Discounts provided to employees serve several key employer purposes. They stimulate sales to a natural group of consumers. It is beneficial to the employer for the employees to be familiar with, to purchase, to use, or be seen using or wearing the merchandise sold in their stores. Retailers have found that persons who have had personal experience with a store's merchandise make more effective salespersons, their morale is higher, and they are often more loyal advocates of their employers and their goods. This rationale applies not only to salespersons, but to other employees as well.

Actually, product discounts probably benefit employers as much as employees since the discount enables employers to increase sales and thus taxable profits while at the same time obtaining merchandise exposure plus a more educated sales force, and promoting the goodwill and efficiency of their employees. For these reasons, it would be difficult for millions of employees to understand why their discounts represent a form of taxable compensation— particularly since they have not heretofore been subject to tax.

Technical Issues

Recordkeeping. The taxation of product discounts would create significant administrative and compliance problems. Retailers would have to establish procedures whereby all store clerks would record the purchase and the discount for each employee making a purchase. This data would then need to be accumulated and submitted to the payroll center. In the past, it has been suggested that a de minimis rule be used. Under this approach, only an amount of discount in excess of a designated annual amount, for example $200, would be taxable. However, this would not reduce the recordkeeping required. It would still be necessary to identify every purchase by each employee in order to determine whether he or she has exceeded the de minimis amount. The recordkeeping changes required to identify every employee's purchase would be costly and represent a significant burden on all retailers. Moreover, this additional cost would be particularly burdensome for small retailers who do not have access to sophisticated computer systems. We question whether any revenue gain resulting from taxing discounts is worth the additional costs of compliance—especially when a tax on the discount will discourage employee purchases.

Valuation Generally. A change in policy to impose a tax on product discounts would also raise a difficult question of valuation. The objective dollar value of a discount simply does not accurately measure its real value. Department store employees may purchase merchandise at discounts of varying rates; comparable merchandise may be available at a promotional sale or at a nearby store at the same or even a lower net price. It is difficult in a case such as this to identify the value that is being taxed, because the employee has purchased the merchandise at one of its many fair market values.

Determining how to accurately but fairly value noncash fringe benefits has been a major stumbling block in attempting to implement new fringe benefit rules. Alternative methods include fair market value, a value determined by the employer, the allocated cost of the facility or service to the employer, and the incremental cost to the employer.

In the fringe benefit area, fair market value is fraught with numerous deficiencies as noted above. It is not always readily or clearly determinable. It also assumes a freedom of choice on the part of the recipient—i.e., given an amount of cash, a fair market value approach assumes the recipient would use it to purchase the item in question. Such use of a fair market value standard would also create controvery as well as misunderstandings with employees to whom employers would have to report such amounts.

The alternative of requiring employers to determine the value would be a step backward. Employers should not be placed in a position where they must make subjective value judgments with respect to an employee's taxable income. The amount of the tax on a fringe benefit must be as clearly and easily determinable as is the taxability of the benefit itself.

A "cost" valuation also poses difficult problems. What should "cost" represent? Should it be an allocated portion of the employer's total cost related to providing specified goods or the use of facilities to employees or the incremental cost incurred by the employer to provide the fringe benefit to employees? It is difficult to argue that either allocated cost or incremental cost would always, or even generally, more closely approximate the true value to the employee. As discussed earlier, it is indeed difficult in most instances to identify precisely the fair market value when one considers the various alternative prices available, the difference in quality, and the employees' freedom of choice from the comparable benefit.

Treasury Comments

In his June 22 statement before the Committee, Assistant Secretary Chapoton discussed merchandise discounts as a specific example of a "nonstatutory fringe benefit" that could be addressed by legislation. Therein, it is suggested that valuation problems related to such discounts could be substantially reduced by statutory or administrative rules "for approximating the fair market value" of such benefits. For example, a rule could presume that an item sold at a discount to employees without a warranty would have a fair market value that is less than the same item sold with a warranty. No doubt such a statement would be seen as reasonable in the abstract. But this approach fails to consider the points discussed above. Consider the situation in which the employee can purchase an identical item with a warranty at a later promotional sale by the employer or at a competitor's store for the same or a lesser price. How can the discount be judged to be the fair market value of a benefit when the employee can realize the same or a greater price reduction at another time or place? Also, what portion of the discount should be allocated to advertising or educational expense directly related to the retailer's production of income? Merely to observe that rules would reduce the problems of valuation does not provide any assurance that such rules would result in correct answers to valuation problems.

The Treasury statement then suggests that valuation problems could be reduced by imposing a form of excise tax on fringe benefits at the employer level. This approach apparently would require a retailer to pay a fixed percentage of the total merchandise discounts for all employees. But this approach does not solve either the valuation or recordkeeping problems posed by taxing the employee directly. Calculating the total dollar amount of discounts below marked retail prices raises the same questions that were discussed above. Such discounts do not necessarily equal either the true benefit to the employee or the lost income of the employer. Furthermore, the cumulative recordkeeping would be only moderately eased by an employer-level tax that still requires the recording and adding together of hundreds of discounts for small companies and hundreds of thousands of discounts for large corporations. Finally, an excise tax would effectively be a new tax on employment - a dramatic change in Congressional and Administration efforts to reduce the cost of employment during this period of high unemployment. In addition, significant administrative and compliance problems would still remain and employers would also have imposed upon them an additional and unfair tax burden generated by a fictional income.

Recommendation

The limited Task Force consideration of the issue in 1978 clearly indicated that the taxation of fringe benefits is a most complex topic. New rules that substantially change the status quo would impact millions of employees and virtually all employers. The consistent administrative practice of the Treasury over many decades has been to view non-discriminatory discounts as not being compensation, and we believe that view represents a correct policy for today.

Union Mutual Life Insurance Company

Position on Taxation of Health Insurance Premiums

The President has recommended and legislation has been introduced to create a cap on the amount of health insurance premiums which are not taxable to the employee. Under the present proposal, amounts employers pay in excess of $2,100 per family or $840 per individual would become taxable income to the employee. The purpose of this paper is to examine that proposal, to indicate Unionmutual's position on it and to urge Congress to consider an alternate proposal.

Position: Unionmutual opposes the cap in its present form. The Company, however, does not oppose the concept of a cap. This Company would support a reasonable limitation on health insurance premiums provided it was designed to assure that it would achieve meaningful cost savings, and was revenue-neutral.

Analysis of Present Proposal: The proposal presently before the Congress poses a number of problems both in terms of equity and of administration that would defeat the purposes for which it is intended. These problems can be summarized as follows:

1. The proposal is inequitable because of Medicare cost shifting. Medicare/Medicaid payment practices shift billions of dollars in hospital expenses to private sector patients. These expenses are paid for through higher insurance premiums. Passage of this proposal would impose a tax on costs created by government action. For the government to shift costs to the private sector and then tax those costs is basically unfair.

2. To the extent plan benefits would need to be reduced, preventive services would be the first to be dropped while hospital protection would be the last to be reduced. Therefore such coverages as dental care, vision care, mental health benefits and drug and alcohol abuse services would no longer be covered.

3. The proposal fails to recognize geographic and age variations. Medical costs vary widely both by geographical area and by age composition of employee groups. A single national cap would necessarily discriminate against employees in high medical cost areas and those in groups with higher than average age. Such a cap could discourage the employment of older workers. Conversely, it would permit young groups and those in low medical cost areas to purchase tax-free much more generous benefit plans than others.

4. Since many employee benefit plans are determined through union negotiation, it is likely that such negotiations would shift employer contributions in excess of the cap to other fringe benefits. Thus, even the expected tax revenue advantage may not materialize.

5. Administration of the dollar ceiling on each individual employee's exclusion is complicated by the fact that in employee group health plans there is no individual premium as such. There is a strong trend to self-insurance among major employers and it is estimated that up to 35% of employee health plans are already self-insured with employers simply paying the bill for covered benefits. There would be a major administrative problem in valuing each individual plan for each individual employee in order to apply the cap and compute the individual's tax, if any.

None of the objections listed above deal with the philosophic question of whether or not fringe benefits should be subject to taxation. Unionmutual opposes taxation of fringe benefits, but recognizes that there should be reasonable levels to which tax-deductibility is confined. It is appropriate for Congress to establish an outside limit, within which employers may exercise the privilege of tax-deductibility to whatever degree they wish.

Analysis of Unionmutual Position: The tax cap proposal of the Administration has the stated purpose of containing health care costs. There also appears to be an unexpressed purpose of raising tax revenues. The first purpose would be achieved, hopefully, by causing people to consider whether or not a particular health care service was really required before using it. This would be true either because the cap would not cover the cost of a number of ancillary services, or because keeping the cost of plans under the cap would require larger deductibles and coinsurance. The second purpose would be achieved by creating taxable income for employees. Unfortunately, the more successful the tactic is in meeting one objective, the less successful it is in achieving the other.

It would seem the purposes outlined above could be met more directly through a limit on the tax-deductibility of health insurance premiums paid by the employer. These limits should be directly related to the end of reducing and containing health care costs by tying the limits to a reasonable set of standards for a health insurance plan. For instance, legislation could require that an employer could deduct the cost of a plan that had certain deductibles and coinsurance, and reimbursed certain covered expenses over a reasonably high out-of-pocket limit. Standards should also include preventive care coverage, and incentives for using less costly settings and services. Thus a "qualified" health plan analogous to the qualified pension plan would be created. Such a plan would reduce the employer's deductions and thereby create tax revenue. Thus, it differs from the present Administration proposal by shifting the burden to the employer and removing it from the employee.

Should an employee be so risk-averse that he wishes first dollar coverage, such plans would surely be available that he could purchase with after-tax dollars, but in that case he will have made the choice and not his employer.

In sum, Unionmutual's proposal would have the following advantages:

1. It would go directly to the containment of health care costs.

2. It would recognize geographic and age variations.

3. Administration would be greatly simplified, and the problem of self-insured plans would be solved.

This Company has carried the banner of health care cost containment for a number of years. This plan would contain health care costs in a very direct way. Unionmutual opposes the present Administration proposal because it would not be effective in containing health care costs. We are convinced that the Tax Code is a suitable road to successful health cost containment, and we should not be afraid to use it. We urge the Congress to consider seriously the merits of our position, and stand ready to discuss our position further with any Member, and to assist in the drafting of any required legislation.

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